

APPENDIX TABLE OF CONTENTS

Opinion of the Seventh Circuit (June 27, 2017)	1a
Order of the District Court on Defendants' Motions to Dismiss (April 5, 2016)	22a
Order of the Seventh Circuit Denying Petition for Rehearing En Banc (August 22, 2017)	37a
Relevant Statutory Provisions	38a

OPINION OF THE SEVENTH CIRCUIT
(JUNE 27, 2017)

IN THE UNITED STATES COURT OF APPEALS
FOR THE SEVENTH CIRCUIT

HOME CARE PROVIDERS, INC., ET AL.,

Plaintiffs-Appellants,

v.

KELLY HEMMELGARN, ET AL.,

Defendants-Appellees.

IN RE: NIGHTINGALE HOME HEALTHCARE,
INC.,

Debtor,

NIGHTINGALE HOME HEALTHCARE, INC.,

Plaintiffs-Appellants,

v.

UNITED STATES OF AMERICA, ET AL.,

Defendants-Appellees.

Nos. 16-2054, 16-3668, & 16-3669

Appeals from the United States District Court for the
Southern District of Indiana, Indianapolis Division.

Nos. 1:16-cv-00303-LJM-TAB, 1:16-cv-00317-LJM-TAB, & 1:16-cv-00583-LJM-TAB—Larry J. McKinney, Judge.

Before: BAUER, FLAUM, and
KANNE, Circuit Judges.

FLAUM, Circuit Judge.

This consolidated appeal was prompted by the federal government’s termination of Nightingale Home Healthcare, Inc.’s Medicare provider agreement. Nightingale sought and received a preliminary injunction from the bankruptcy court that prevented the government from terminating Nightingale’s agreement. On appeal, the district court concluded that the bankruptcy court had lacked jurisdiction to issue an injunction and reversed the order. We conclude, however, that the issue of whether the bankruptcy court properly granted the injunction was moot, as the bankruptcy court had dissolved the underlying injunction prior to the district court’s ruling. Separately, Home Care Providers, Inc., Nightingale’s sole shareholder, and its owner, Dr. Dev A. Brar, filed a civil action in the district court, alleging that certain Indiana state surveyors had committed various constitutional violations leading up to Nightingale’s Medicare termination.¹ The district court dismissed those claims with prejudice. We conclude Nightingale’s and Dr. Brar’s constitutional claims were also jurisdictionally barred, pursuant to 42 U.S.C. § 405(g), and

¹ For the remainder of the opinion, we refer to Nightingale, Home Care Providers, any other related subsidiaries, and Dr. Brar as simply, “Nightingale.”

vacate and remand with instructions to dismiss without prejudice.

I. Background

Nightingale Home Healthcare, Inc. provides home health care services in a number of states, including Indiana. In the course of this business, Nightingale signed a provider agreement with the United States Secretary of Health and Human Services to receive Medicare reimbursements and agreed to conform to certain statutory and regulatory requirements.

In October and November 2015, the Indiana State Department of Health (“ISDH”) conducted a survey at one of Nightingale’s facilities and concluded that Nightingale had failed to comply with the applicable requirements.² The ISDH found that Nightingale’s deficiencies placed its patients in “immediate jeopardy,”³ and recommended that the Centers for Medicare & Medicaid Services (“CMS”), which administers Medicare, terminate Nightingale’s Medicare agreement. On November 17, CMS notified Nightingale

² Under 42 U.S.C. § 1395bbb(c), home health agencies are subject to periodic surveys to determine whether they are in compliance with certain statutory and regulatory requirements. These surveys can be carried out by state agencies pursuant to a contract with the Secretary. 42 U.S.C. §§ 1395aa, 1395bbb(c).

³ “Immediate jeopardy” is defined as “a situation in which the provider’s noncompliance with one or more requirements of participation has caused, or is likely to cause, serious injury, harm, impairment, or death” to a patient. 42 C.F.R. § 488.805. If the Secretary determines that deficiencies “immediately jeopardize the health and safety of the individuals to whom the agency furnishes items and services, the Secretary shall take immediate action to correct the deficiencies,” up to and including termination of provider agreements. 42 U.S.C. § 1395bbb(e)(1).

that the agency would terminate Nightingale's agreement on December 10, unless Nightingale corrected its irregularities. Later, on December 8 and 9, the ISDH conducted a revisit survey and concluded that Nightingale had failed to comply, and CMS informed Nightingale that its provider agreement would terminate as scheduled. Nightingale filed an administrative appeal and requested expedited review.

A. Bankruptcy Proceedings

On December 10, before CMS terminated the Medicare agreement, Nightingale filed a voluntary petition to reorganize in bankruptcy. Nightingale then commenced an adversary proceeding in the United States Bankruptcy Court for the Southern District of Indiana against federal and state officials administering the Medicare program, invoking the court's subject-matter jurisdiction under 28 U.S.C. §§ 157(b)(1) & 1334. Nightingale filed a complaint and an emergency motion for a preliminary injunction, seeking (1) to enjoin CMS from terminating its provider agreement during the pendency of the reorganization and completion of administrative appeals, (2) to compel CMS to pay out Medicare receivables purportedly due for services already provided, and (3) to compel CMS to continue to reimburse Nightingale for services rendered after the agreement's termination. The federal government moved to dismiss Nightingale's complaint for lack of jurisdiction.

On January 19, 2016, the bankruptcy court held an evidentiary hearing on Nightingale's request for injunctive relief. It granted the motion on January 25, directing the federal government to abide by the Medicare provider agreement. The court cautioned

Nightingale that it was still obligated to comply with the applicable Medicare requirements. Finally, the court concluded that 28 U.S.C. § 1334 provided a basis for exercising jurisdiction over Nightingale's property, including, in relevant part, its provider agreement to participate in Medicare, and could thus preserve the status quo pending exhaustion of Nightingale's administrative appeals. Thus, the court explained, the terms of the provider agreement would remain in place. The court later repeated this holding in denying the government's motion to dismiss for lack of subject-matter jurisdiction. The federal government timely sought review of the bankruptcy court's decisions in the district court.

On April 22, while the government's appeal was pending, the ISDH investigated several complaints concerning Nightingale's post-petition services. The agency again found that Nightingale was placing patients in "immediate jeopardy." The federal government subsequently sought relief from the bankruptcy court's preliminary injunction, and the court dissolved the injunction on July 15. CMS notified Nightingale that CMS would terminate the provider agreement on July 16.

On May 9, a Medicare Administrative Law Judge ("ALJ") affirmed the termination of Nightingale's provider agreement. The ALJ concluded that the evidence overwhelmingly proved that Nightingale had violated regulatory and statutory requirements, and that those deficiencies placed patients in "immediate jeopardy." Nightingale appealed the ALJ's decision to the Departmental Appeals Board in June. (Recently, on April 14, 2017, the Board affirmed the ALJ's

decision, constituting a final administrative decision on Nightingale's claims).

On June 2, 2016, Nightingale sought the bankruptcy court's authority to sell all of its assets. After failing to complete a sale by July, however, Nightingale began discharging its patients and winding down Indiana business operations. As of August 17, 2016, Nightingale had completely halted its business in Indiana.

Finally, on September 16, 2016, the district court addressed the federal government's bankruptcy appeal. The court concluded that the bankruptcy court had lacked subject-matter jurisdiction to issue the preliminary injunction, pursuant to 42 U.S.C. § 405(h) of the Social Security Act.⁴ Although the bankruptcy court had already dissolved the injunction, the court rejected Nightingale's argument that the government's appeal was moot, explaining that the government could still seek restitution for the nearly \$5 million in reimbursements it had provided for Nightingale's post-injunction services. After the district court issued its opinion, CMS filed a claim for restitution that is currently pending,⁵ and Nightingale timely filed this appeal.

⁴ Under 42 U.S.C. § 1395ii, the provisions of 42 U.S.C. § 405(h) "shall [] apply with respect to [the Medicare Act] to the same extent as they are applicable with respect to [the Social Security Act]."

⁵ CMS brought its separate restitution claim before the bankruptcy court on July 21, 2016, while this case was pending before the district court. The bankruptcy court denied the government's request, and the government appealed the matter to the district court. Upon a joint motion, the district court then stayed the restitution case pending the outcome of this appeal.

B. Constitutional Claims

Separately, on February 4, 2016, Nightingale initiated a civil proceeding in federal court against Sylvia Matthews Bur-well, then-Secretary of the United States Department of Health and Human Services; Jerome Adams, Commissioner of the Indiana State Department of Health; and Kelly Hemmelgarn, Randall Snyder, and Ingrid Miller, three Indiana state surveyors. According to the complaint, the defendants had collectively abused the Medicare survey process, violating Nightingale's (1) equal-protection, (2) First Amendment, (3) due-process, and (4) Fourth Amendment rights. Nightingale requested an order directing the state defendants to withdraw all of the survey reports issued against Nightingale since January 1, 2015, including those underlying the termination of Nightingale's Medicare agreement. Nightingale also sought an injunction preventing CMS from using the Indiana State Department of Health to conduct further surveys of Nightingale, or an order directing Indiana to conduct surveys against Nightingale only upon the filing of a bona fide, third-party complaint alleging facts likely to constitute an immediate threat to the health and well-being of patients. Finally, Nightingale requested money damages from the state surveyors.

Defendants moved to dismiss Nightingale's complaint, arguing that the district court lacked subject-matter jurisdiction under Federal Rule of Civil Procedure 12(b)(1), and that the complaint failed to state a claim for which relief could be granted under Rule 12(b)(6). The district court granted both motions and dismissed the case with prejudice. This appeal followed.

On May 1, 2017, while this appeal was pending, Nightingale moved to dismiss its case against the Secretary and the Commissioner, and all claims for equitable relief, as Nightingale had ceased its operations in Indiana. All that remains are Nightingale's constitutional claims against the state surveyors and its request for damages.

II. Discussion

A. Bankruptcy Appeal

As a threshold matter, Nightingale asserts that the bankruptcy case was moot prior to the district court's decision, because the bankruptcy court had already dissolved the injunction at issue. The government does not dispute that the bankruptcy court had dissolved the injunction, but argues that its separate restitution action (now pending before the district court) presented a live and equitably redressable controversy. "Whether a case has been rendered moot is a question of law that we review *de novo*." *Fed'n of Advert. Indus. Representatives, Inc. v. City of Chi.*, 326 F.3d 924, 928-29 (7th Cir. 2003) (citation omitted). "Under Article III of the Constitution, the judicial power of the United States extends only to cases and controversies." *Wis. Right to Life, Inc. v. Schober*, 366 F.3d 485, 488 (7th Cir. 2004) (citing *Steel Co. v. Citizens for a Better Env't*, 523 U.S. 83, 102, 118 S.Ct. 1003, 140 L.Ed.2d 210 (1998)). "This jurisdictional requirement ensures that the resources of the federal judiciary are not expended on advisory opinions and hypothetical disputes." *Id.* Accordingly, "cases that do not involve 'actual, ongoing controversies' are moot and must be dismissed for lack of jurisdiction." *Id.* at 490-91. (quoting *Fed'n*, 326 F.3d at 929). Nightingale,

the party asserting mootness, bears the burden of persuasion. *Id.* at 491 (citation omitted).

The scope of an appellate court's review over a preliminary injunction that has expired while on appeal is controlled by the Supreme Court's decision in *University of Texas v. Camenisch*, 451 U.S. 390, 101 S.Ct. 1830, 68 L.Ed.2d 175 (1981); *see also Nat'l Kidney Patients Ass'n v. Sullivan*, 902 F.2d 51, 54 (D.C. Cir. 1990) (*Kidney Patients I*) (citing *Camenisch*, 451 U.S. at 394-95, 101 S.Ct. 1830). In *Camenisch*, a deaf graduate student sought and received injunctive relief that required the University of Texas to appoint him a sign-language interpreter. *Id.* at 392, 101 S.Ct. 1830. The university appealed the injunction decision and, while that appeal was pending, the university paid for the plaintiff's interpreter, and the plaintiff graduated. *Id.* at 393, 101 S.Ct. 1830. The Fifth Circuit affirmed the injunction and rejected the notion that the case was moot, explaining that the issue of who should pay for the interpreter still remained. *Id.* The Supreme Court, however, concluded that the appeal was moot, because the terms of the injunction had been fully carried out. *Id.* at 398, 101 S.Ct. 1830. The question of who should bear the cost of the injunction was "significantly different" from the "[validity of the] injunction itself," and could not breathe life into the now-moot controversy. *See id.* at 393, 101 S.Ct. 1830 ("[T]he issue before the Court of Appeals was not who should pay for the interpreter, but rather whether the District Court had abused its discretion in issuing a preliminary injunction requiring the University to pay for him. The two issues are significantly different . . .") (internal citations omitted). Instead, the case was "simply another instance in

which one issue in a case ha[d] become moot, but the case as a whole remain[ed] alive because other issues ha[d] not become moot.” *Id.* (citation omitted). Because the injunction was the only issue before the Court at that time, *id.* at 394, 101 S.Ct. 1830, the Court concluded that it lacked jurisdiction and remanded the case to the district court for a trial on the merits to address questions of costs, *id.* at 398, 101 S.Ct. 1830.

Here, the case before the district court—sitting as a court of review—was indistinguishable from *Camenisch*. The issue on appeal was whether the bankruptcy court had improperly implemented the preliminary injunction, and that issue became moot once the bankruptcy court dissolved the injunction. Unfortunately for the government, courts of review may consider only the issues raised before them. *See Camenisch*, 451 U.S. at 393, 101 S.Ct. 1830; *see also St. Pierre v. United States*, 319 U.S. 41, 42, 63 S.Ct. 910, 87 L.Ed. 1199 (1943) (“A federal court is without power to decide moot questions or to give advisory opinions which cannot affect the rights of the litigants in the case before it.” (citing *United States v. Alaska S.S. Co.*, 253 U.S. 113, 115, 40 S.Ct. 448, 64 L.Ed. 808 (1920))) (emphasis added); *Kidney Patients I*, 902 F.2d at 54 (citation omitted). In fact, unlike the university in *Camenisch*, the government has not presented a restitution issue on appeal; rather, it brought the restitution claim as a separate lawsuit that is still pending before the district court. Because a party cannot avoid mootness by making reference to a different live issue, it follows that it cannot do so using an entirely separate action. Accordingly, the district court lacked jurisdiction to address the merits of the injunction, and the government’s separate

restitution action did not revive that court's jurisdiction. *See Camenisch*, 451 U.S. at 393-95, 101 S.Ct. 1830; *see also Orion Sales, Inc. v. Emerson Radio Corp.*, 148 F.3d 840, 842 (7th Cir. 1998) (“[R]eview of a preliminary injunction that has become moot would run afoul of the constitutional command that limits our jurisdiction to cases and controversies.”) (citation and quotation marks omitted); *Henco, Inc. v. Brown*, 904 F.2d 11, 13-14 (7th Cir. 1990) (“[T]he issue of whether the district court should have issued the preliminary injunction is moot because the injunction has dissolved . . . well before this appeal was heard. It would be inappropriate for this court to intimate any view on the merits of the parties’ competing claims . . .”).⁶

⁶ Although the parties did not rely on it here, the Supreme Court’s decision in *Liner v. Jafco, Inc.*, 375 U.S. 301, 84 S.Ct. 391, 11 L.Ed.2d 347 (1964), is often cited for the proposition that parties prejudiced by erroneously granted injunctions may avoid mootness notwithstanding the dissolution of the underlying injunction. *See id.* at 305-06. We note two distinctions between our case and *Liner*. First, the injunction in *Liner* included an injunction bond that constituted the legal interest precluding mootness. *id.* at 394 (“The petitioners plainly have a substantial stake in the judgment [affirming an injunction] which exists apart from and is unaffected by the [injunction’s dissolution]. Their interest derives from . . . respondent[s]. . . . [t]he injunction bond [requiring it] to indemnify them in damages if the injunction was ‘wrongfully’ sued out.”) (internal citation and quotation marks omitted). Here, the underlying injunction included no such bond. Consol. Appx at 37. (“Debtor shall not be required to post the security that would otherwise be required under Fed. R. Civ. P. 65(c), made applicable to the Adversary Proceeding by Fed. R. Bankr. P. 7065.”). Second, the injunction in *Liner* was permanent, not preliminary. *See Camenisch*, 451 U.S. at 396 (“[W]here a federal district court has granted a preliminary injunction, the parties generally will have had the

The government’s reliance on *Arkadelphia Milling Co. v. St. Louis Southwestern Railway Co.*, 249 U.S. 134, 145-46 (1919), is unpersuasive. In *Arkadelphia*, railway companies had sought and received injunctions to restrain the enforcement of certain intrastate freight and passenger rates. *Id.* at 137-38. In assessing the defendants’ appeal against the injunctions, the Supreme Court delineated the equitable principle that a party against whom an erroneous judgment has been carried into effect is entitled to be restored. *Id.* at 145. The power to carry out that principle, however, is only inherent in a court “so long as it retains control of the subject-matter.” *Id.* at 146 (emphasis added). In this case, the issue was moot by the time it came before the district court, and, as a result, the district court lacked subject-matter jurisdiction. *See Pakovich v. Verizon LTD Plan*, 653 F.3d 488, 492 (7th Cir. 2011). Thus, no equitable relief was permissible.

The government’s reliance on *National Kidney Patients Association v. Sullivan*, 958 F.2d 1127, 1136-37 (D.C. Cir. 1992) (*Kidney Patients II*), meets the same fate. There, the government challenged an injunction enjoining it from reducing Medicare reimburse-

benefit neither of a full opportunity to present their cases nor of a final judicial decision based on the actual merits of the controversy. Thus when the injunctive aspects of a case become moot on appeal of a preliminary injunction, any issue preserved by an injunction bond can generally not be resolved on appeal, but must be resolved in a trial on the merits. Where, by contrast, a federal district court has granted a permanent injunction, the parties will already have had their trial on the merits, and, even if the case would otherwise be moot, a determination can be had on appeal of the correctness of the trial court’s decision on the merits, since the case has been saved from mootness by the injunction bond.”).

ments for certain treatments and eventually sought recoupment of amounts paid under the injunction. *Id.* at 1129. Before addressing recoupment in *Kidney Patients II*, however, the court had concluded in a previous opinion that the injunction issue had been mooted by newly-enacted legislation, stripping the court of subject-matter jurisdiction. *Id.* (citing *Kidney Patients I*, 902 F.2d at 55); *see also Kidney Patients I*, 902 F.2d at 54-55. In fact, in *Kidney Patients I*, the court had rejected the argument that the government now proffers, stating,

[T]he recoupment of any reimbursement for [the expenses at issue] . . . was not presented on appeal. Those claims must first be determined by the trial court on the merits before they can furnish a basis for appellate review The only issue presently before us—the correctness of the decision to grant a preliminary injunction—is no longer justiciable. Accordingly, the appeal is dismissed

902 F.2d at 54-55 (internal citations omitted). This case mirrors *Kidney Patients I*, and we likewise conclude that the “correctness of the decision to grant a preliminary injunction” was moot. *Id.* at 55.

This leads us to the question of vacatur. The government argues that if there is no longer a controversy regarding the preliminary injunction, this court should simply dismiss the appeal, not reverse the lower court’s judgment. *See Orion*, 148 F.3d at 843. Thus, concludes the government, the district court’s decision that the bankruptcy court lacked jurisdiction to issue the injunction should be left intact. While the government’s reasoning is correct, its con-

clusion ignores the additional layer of review in bankruptcy cases. In *Orion*, the district court’s preliminary injunction became moot, and this Court, the first reviewing court, dismissed the appeal without disturbing the district court’s order granting the injunction. *Id.* Here, the bankruptcy court’s injunction became moot, and the district court was the first to review the bankruptcy court’s order. This procedural posture makes all the difference: Because we conclude that the injunction had expired before the district court had issued its ruling, that court should have dismissed the appeal as moot, leaving the bankruptcy court’s orders undisturbed. *See Certified Grocers v. Produce Union, Local 703*, 816 F.2d 329, 332 (7th Cir. 1987) (“[A]ppeals from expired preliminary injunctions should be dismissed without vacating the underlying order.”) (citing *Gjertsen v. Bd. of Election Comm’rs*, 751 F.2d 199 (7th Cir. 1984)). As such, we vacate the district court’s judgment reversing the bankruptcy court’s injunction orders.⁷

⁷ Our decision leaves the parties free to dispute the merits of the injunction as it relates to the government’s restitution action—a live issue pending in the district court. In the event either party is dissatisfied with the outcome of that action and files an appeal, we can review the merits of the underlying decisions then. *See Henco*, 904 F.2d at 13 (“If [appellant] eventually moves the district court for damages on the injunction bond and is dissatisfied with the district court’s ruling, we can review the correctness of the trial judge’s decision after the district court has had an opportunity to fully deliberate on the merits of the parties’ claims.”).

B. Constitutional Claims

We turn next to Nightingale’s constitutional challenges. Like the bankruptcy appeal, this dispute begins and ends with jurisdiction.

Nightingale argues that its claims invoked the district court’s subject-matter jurisdiction under 42 U.S.C. § 405(g).⁸ Typically, “an institution dissatisfied with a final decision by the Secretary to terminate its Medicare provider agreement may obtain judicial review of the matter in accordance with 42 U.S.C. s 405(g).” *Northlake Cmty. Hosp. v. United States*, 654 F.2d 1234, 1240 (7th Cir. 1981) (citing 42 U.S.C. § 1395ff(c)). Review is available, however, only if that institution satisfies three requirements: It must (1) bring an action “after any final decision of the Secretary made after a hearing to which (the provider) was a party;” (2) commence the action within sixty days after the mailing of the notice of decision by the Secretary or within such time as the Secretary may allow; and (3) file the action in an appropriate court. *Id.* (citing 42 U.S.C. § 405(g)). The Supreme Court has regarded the “requirement that there be a final decision by the Secretary after a hearing” as “central to the requisite grant of subject-matter jurisdiction.” *Mathews v. Eldridge*, 424 U.S. 319, 328 (1976) (quoting *Weinberger v. Salfi*, 422 U.S. 749, 764 (1975)). This requirement consists of two elements, “only one of which is purely ‘jurisdictional’ in the sense that it

⁸ Although Nightingale did not assert jurisdiction based on § 405(g) in its complaint, it argues on appeal that we may nonetheless recognize it as a basis for federal jurisdiction. *See Littleton v. Berbling*, 468 F.2d 389, 395 (7th Cir. 1972). We need not reach this issue, however, because Nightingale did not comply with § 405(g)’s administrative-exhaustion requirement.

cannot be ‘waived’ by the Secretary in a particular case.” *Id.* “The waivable element is the requirement that the administrative remedies prescribed by the Secretary be exhausted. The nonwaivable element is the requirement that a claim for benefits shall have been presented to the Secretary.” *Id.*

Nightingale does not dispute that it failed to exhaust its administrative remedies. Indeed, only on April 14, 2017—some fourteen months after Nightingale filed its action against the state surveyors—did the Board issue its final decision upholding the government’s termination of Nightingale’s Medicare agreement. Instead, Nightingale argues that this case falls within an exception, allowing for waiver of the exhaustion requirement. We have previously detailed the two circumstances in which waiver is appropriate:

If the Secretary determines that additional administrative review would be futile either because the agency’s needs have been satisfied or because the requested relief is beyond the agency’s power to confer the Secretary may waive the exhaustion requirement at any stage of the administrative process. Similarly, if the claimant raises a constitutional challenge which is entirely collateral to his claim of entitlement, and the claimant’s interest in having the issue resolved promptly is so great that deference to the agency’s judgment is inappropriate, the court may waive the exhaustion requirement.

Northlake, 654 F.2d at 1241 (internal quotation marks and alterations omitted (quoting *Eldridge*, 424 U.S. at 330) (citing *Salfi*, 422 U.S. at 765-67)). This

case does not fall into either of these exceptions. The Secretary has not waived Nightingale's exhaustion requirement, and the constitutional claims are either not "colorable," not "entirely collateral" to Nightingale's substantive entitlement claims, or both. *See id.* ("The mere assertion of a constitutional claim is not enough" to mandate a waiver of § 405(g)'s exhaustion prerequisite; "the record before the court must present a colorable constitutional claim.") (citation omitted).

As pled, most of Nightingale's constitutional challenges are not entirely collateral to its substantive entitlement claims. It alleged, in part, "class-of-one" and racial discrimination equal-protection claims, a First Amendment claim, and a due-process claim—all based on its allegations that the state surveyors subjected them to an inordinate number of surveys and administrative complaints, issued harsh findings and reports, and failed to provide specific information regarding the Medicare termination, all without a rational basis. "A party," however, "cannot avoid the Medicare Act's jurisdictional bar simply by styling its attack as a claim for collateral damages instead of a challenge to the underlying denial of benefits." *Bodimetric Health Servs., Inc. v. Aetna Life & Cas.*, 903 F.2d 480, 487 (7th Cir. 1990). Indeed, "[i]f litigants who have been denied benefits could routinely obtain judicial review of these decisions by recharacterizing their claims under state and federal causes of action, the Medicare Act's goal of limited judicial review for a substantial number of claims would be severely undermined." *Id.* (citing *Bowen v. Mich. Acad. of Family Physicians*, 476 U.S. 667, 680 n.11 (1986)). We understand Nightingale's claims to be administrative challenges framed as collateral constitutional ones—

inappropriately attacking the survey results underlying Nightingale's Medicare termination. *See id.* at 484-86 (citing *United States v. Erika*, 456 U.S. 201 (1982)). It is telling that Nightingale originally sought orders to remove the state's survey results and prevent the state from surveying Nightingale moving forward.⁹ The applicable Medicare regulations provided Nightingale an opportunity to challenge the surveyors' approach in a two-tiered appellate system, including formal evidentiary hearings and opportunities to present written argument. *See generally* 42 U.S.C. § 1395cc(h)(1); 42 C.F.R. §§ 431.153, 498.40-498.66, 498.80, 498.85-86. Indeed, Nightingale availed itself of this process, but filed the present civil action before receiving a final decision. This it cannot do.

Moreover, Nightingale's generalized allegations do not amount to colorable constitutional challenges. Plaintiffs alleging equal-protection violations must identify, at a minimum, the type of discrimination suffered, by whom, and when. *See Swanson v. Citibank, N.A.*, 614 F.3d 400, 405 (7th Cir. 2010) (citations omitted). Nightingale's class-of-one claim fails to include integral details regarding what the survey and inspection process normally entails; how Nightingale's survey process deviated from that process; which particular surveys or inspections were "harsh" and how; or whether the state surveyors strayed from the applicable regulatory and statutory guidelines governing the survey process. And Nightingale's claim that the allegedly harsh survey process was due to

⁹ Although Nightingale now seeks only damages, they do so because they have ceased operating in Indiana; this does not alter our interpretation of its claims as they were originally pled.

racial animus fares no better. The only evidence Nightingale points to is a voicemail left by defendant Snyder's unnamed colleague, during which the individual purportedly voiced "racially tinged" remarks in the background after forgetting to disconnect the call. Nightingale fails, however, to connect these remarks to any named state surveyor. The remainder of Nightingale's allegations rely on general speculation that the state surveyors were motivated by race. Without more, Nightingale's equal-protection claims do not rise to the level of colorable constitutional challenges.

Further, Nightingale did not include arguments or cite to legal authority in its opening brief regarding its First Amendment or due-process claims. It has thus waived any argument on appeal that these claims are colorable. *See, e.g., United States v. Beavers*, 756 F.3d 1044, 1059 (7th Cir. 2014) ("Perfunctory, undeveloped arguments without discussion or citation to pertinent legal authority are waived." (quoting *Mahaffey v. Ramos*, 588 F.3d 1142, 1146 (7th Cir. 2009))).

Finally, Nightingale's Fourth Amendment claim lacks sufficient detail. Nightingale alleged that the state surveyors conducted an unreasonable search and seizure by entering one of its former business premises and rummaging through desks. It is not clear, however, whether Nightingale owned the building, given that the complaint describes the building as "former business premises." (emphasis added). *See United States v. Fuesting*, 845 F.2d 664, 671 (7th Cir. 1988) ("It is well-established that Fourth Amendment rights are personal rights which . . . may not be vicariously asserted A person who is aggrieved by an illegal

search and seizure only through the introduction of damaging evidence secured by a search of a third person's premises or property has not had any of his Fourth Amendment rights infringed") (citations and internal quotation marks omitted). It is equally unclear what Nightingale's alleged damages are, because there is no allegation that the state surveyor obtained any information from in-side the building or any details of what that information entailed. Without more, Nightingale has failed to present a colorable Fourth Amendment claim. *See Eastern Bridge, LLC v. Chao*, 320 F.3d 84, 91 (1st Cir. 2003) ("Plaintiffs also assert that because they are alleging a Fourth Amendment violation, they need not exhaust administrative remedies. But this invocation of constitutional authority, without more, cannot breathe life into a theory already pronounced dead by the Supreme Court in binding precedent.").

This case thus does not call for us to waive § 405(g)'s administrative-exhaustion requirement. Given that Nightingale failed to satisfy all three of § 405(g)'s requirements, the district court correctly determined that it was statutorily barred from considering the case. The district court, however, dismissed the claims with prejudice. Because we conclude that the claims are jurisdictionally barred by § 405(g), the complaint should be dismissed without prejudice. *See Frederiksen v. City of Lockport*, 384 F.3d 437, 438-39 (7th Cir. 2004) ("A jurisdictional disposition is conclusive on the jurisdictional question: the plaintiff cannot re-file in federal court. But it is without pre-

judice on the merits . . .” (citing *T.W. v. Brophy*, 124 F.3d 893, 898 (7th Cir. 1997))).¹⁰

III. Conclusion

For the foregoing reasons, we VACATE the judgment of the district court regarding the bankruptcy appeal, and REMAND to the district court for further proceedings. Additionally, we VACATE the judgment of the district court regarding the constitutional claims and REMAND with instructions to dismiss these claims without prejudice for lack of subject-matter jurisdiction.

¹⁰ In light of our conclusion that Nightingale’s claims were jurisdictionally barred under § 405(g)’s administrative-exhaustion requirement, we offer no opinion regarding whether these claims were barred by § 405(h).

ORDER OF THE DISTRICT COURT
ON DEFENDANTS' MOTIONS TO DISMISS
(APRIL 5, 2016)

UNITED STATES DISTRICT COURT
SOUTHERN DISTRICT OF INDIANA
INDIANAPOLIS DIVISION

HOME CARE PROVIDERS, INC., NIGHTINGALE
HOME HEALTHCARE, INC., NIGHTINGALE
HOSPICE CARE, INC., and DEV A. BRAR,

Plaintiffs,

v.

KELLY HEMMELGARN, RANDALL SNYDER,
JEROME M. ADAMS Commissioner of the Indiana
State Department of Health, SYLVIA MATHEWS
BURWELL Secretary of the United States
Department of Health and Human Services,
and INGRID MILLER,

Defendants.

No. 1:16-cv-00303-LJM-TAB

Before: Larry J. McKINNEY, Judge,
United States District Court

Defendant Sylvia Mathews Burwell, Secretary of
the United States Department of Health and Human
Services (the "Secretary") has moved to dismiss the
claims brought against it by Plaintiffs Home Care

Providers, Inc., Nightingale Home Healthcare, Inc., Nightingale Hospice Care, Inc. (these three Defendants, collectively, “Nightingale”) and Dev A. Brar (“Brar”) (all plaintiffs, collectively, “Plaintiffs”). Dkt. No. 13. The Secretary argues that the Court lacks jurisdiction over Plaintiffs’ claims for multiple reasons. Dkt. Nos. 14 & 33. Plaintiffs argue, among other reasons, that the Court has jurisdiction over their claim for injunctive relief pursuant to *Ex Parte Young*, 209 U.S. 123 (1908), and its progeny. Dkt. No. 26.

Further, Defendants Kelly Hemmelgarn (“Hemmelgarn”), Randall Snyder (“Snyder”), Jerome M. Adams (“Adams”), Commissioner of the Indiana State Department of Health (“ISDH”), and Ingrid Miller (“Miller”) (these defendants, collectively, “State Defendants”) have also moved to dismiss Plaintiffs’ Complaint on similar grounds, namely that Plaintiffs lack standing and/or the Court lacks jurisdiction. Dkt. No. 29 & 30. Plaintiffs contend that the cases the State Defendants rely upon apply only to federal employees, officer and agencies, not state actors and that they have been directly harmed by the actions of the Defendants. Dkt. No. 38.

For the reasons stated herein, the Court GRANTS the Secretary’s and the State Defendants’ Motions to Dismiss.

I. Factual Allegations & Statutory Scheme

The Medicare Act, 42 U.S.C. § 1395 *et seq.*, established a national program of health coverage for the aged and disabled. Among other services, Medicare provides coverage for a certain defined “home health services,” including “part-time or intermittent nursing care,” which are furnished on a “visiting basis” by a

home health agency to a Medicare beneficiary in his or her home. 42 U.S.C. § 1395x(m) (home health services). *See also* 42 U.S.C. §§ 1395x(o) (home health agency) & 1395bbb; 42 C.F.R. Part 484 (conditions for participation for home health agency). Among other responsibilities, the Secretary oversees the Centers for Medicare & Medicaid Services (“CMS”), which operates and administers the Medicare program.

Congress has authorized CMS to enter into agreements with state survey agencies, such as the ISDH, to conduct periodic surveys of home health agencies to determine compliance with the Medicare participation requirements. 42 U.S.C. § 1395aa(a). *See also* 42 C.F.R. §§ 488.10, 488.11, 488.20. CMS bases its determination regarding continued participation in the Medicare program on the results of those surveys; CMS is legally entitled to rely on those surveys to ensure that providers meet certain standards. 42 C.F.R. §§ 488.11, 488.12. The Secretary, through CMS, has entered into an agreement with ISDH that designates ISDH as the state survey agency responsible for the performance of the certification functions created by the Act. Ind. Code § 16-28-12-1. *See also Advantage Home Health Care, Inc. v. Ind. State Dep’t of Health*, 829 N.E.2d 499, 501 (Ind. 2005); *Woodruff v. Wilson*, 484 F.Supp.2d 876, 880 (S.D. Ind. 2007). ISDH also ensures that providers comply with Indiana State regulations and conduct surveys on Indiana’s behalf as well. *See Advantage Home Health Care*, 829 N.E.2d at 501 (explaining the process of ISDH’s inspection and the two reports that are generated therefrom); *see also* Ind. Code § 16-27 *et seq.*

A home health agency may also voluntarily choose to participate in a CMS-approved accreditation program by a private accreditation organization. If the home health agency passes the organization's periodic accreditation surveys, then the Secretary may "deem" the home health agency to meet Medicare's conditions of participation, as opposed to being certified through a State or CMS survey. 42 U.S.C. § 1395bb; 42 C.F.R. § 488.6. However, the Secretary's relationship with a private organization is not the same as its relationship with a State survey agency. A state agency may still conduct "validation surveys" to validate the integrity of the private accreditation process, and complaint surveys. 42 U.S.C. § 1395aa(c); 42 C.F.R. § 488.7. If a state survey finds noncompliance with a condition of participation, the home health agency is placed under the survey jurisdiction of the state agency until it returns to substantial compliance or is terminated. 42 C.F.R. § 488.8(d)-(e).

If a health care provider is failing to meet Medicare requirements, then the Secretary, through CMS may terminate the providers' participation in the Medicare program. 42 U.S.C. § 1395cc(b)(2). See also 42 C.F.R. § 489.53(a). Providers may then appeal CMS's determination through the administrative appeal procedure set forth in 42 C.F.R. Part 498. See 42 C.F.R. § 498.3(b)(8). Under this administrative scheme, the provider may seek review before an Administrative Law Judge, 42 C.F.R. § 498.40 *et seq.*, and then, if unsuccessful, the provider may appeal to the Departmental Appeals Board, 42 C.F.R. § 498.80 *et seq.* The Departmental Appeals Board decision constitutes the Secretary's "final decision." 42 C.F.R. § 498.90.

A dissatisfied provider is entitled to “judicial review of the Secretary’s final decision after such hearing as is provided in section 405(g).” 42 U.S.C. § 1395cc(h)(1); 42 U.S.C. § 405(g) (“Any individual, after any final decision of the Secretary made after a hearing to which [it] was a party . . . may obtain a review of such decision by a civil action commenced within 60 days after the mailing to [it] of notice of such decision.”).

As noted above, ISDH also issues a state survey report. Based on those findings, ISDH has the authority to, among other penalties, revoke a provider’s license or impose civil money penalties. Ind. Code. § 16-27-1-12 (for a home health agency); Ind. Code § 16-25-5-3 (for a hospice). If ISDH revokes a provider’s license or imposes one of the other penalties under Indiana Code § 16-27-1-12 or Indiana Code § 16-25-5-3, the action is reviewable under Indiana’s Administrative Orders and Procedures Act (“IAOPA”), Indiana Code § 4-21.5 *et seq.* *See* Ind. Code § 16-25-5-6.

Nightingale is a “home health agency” that has been in operation for twenty years. Compl. ¶¶ 7, 9, 26. As a “home health agency,” Nightingale is classified as a “provider” of services under the Medicare program and has participated in the Medicare program. *See, generally*, Compl.; 42 U.S.C. § 1395x(u); 42 C.F.R. § 498.2. Nightingale is owned by Brar. Compl. ¶¶ 5,6.

In the Fall of 2015, surveyors from the ISDH conducted complaint surveys at a Nightingale facility and made findings regarding patient health and safety. Compl. ¶¶ 48-50. *See also* 42 C.F.R. § 484.10 *et seq.* Based on these findings, CMS notified Night-

ingale that it was terminating Nightingale's participation in the Medicare program. Compl. ¶¶ 54, 56. Nightingale has initiated an administrative appeal of that determination under 42 C.F.R. Part 498, which is pending. Compl. ¶¶ 55-56.

One of the Nightingale entities has also filed for bankruptcy and is challenging the Medicare reimbursement termination through an adversary bankruptcy action ("Bankruptcy Action"). *See In re Nightingale Home Healthcare, Inc.*, Case No. 1-15-10099-JMC-11 (Bankr. S.D. Ind.); *Nightingale Home Healthcare, Inc. v. Burwell*, Case No. 1-15-50340-JMC-11 (Bankr. S.D. Ind.). In the Bankruptcy Action, Nightingale sought "a temporary restraining order or preliminary injunction and final injunctive relief enjoining the Defendants from terminating Nightingale's participation in the Medicare and Medicaid programs until its challenges to the Defendants' actions have been heard and decided by an administrative law judge" *In re Nightingale Home Healthcare, Inc.*, Case No. 1-15-10099-JMC-11, Dkt. No. 1, Compl. ¶ 62. The Bankruptcy Court issued a preliminary injunction pending an administrative appeal of Nightingale's termination. *See Nightingale Home Healthcare, Inc. v. Burwell*, Case No. 1-15-50340-JMC-11; *United States v. Nightingale Home Healthcare, Inc.*, Case No. 1:16-cv-00317-LJM-TAB, Dkt. No. 5.

Plaintiffs have sued the Secretary in her "official capacity" for injunctive, prospective relief. Compl. ¶ 14. Plaintiffs claim that the Secretary violated the Due Process Clause of the Fifth Amendment, the Equal Protection component of the Due Process Clause of the Fifth Amendment, and the First Amend-

ment of the United States Constitution “[b]y ratifying the other Defendants’ actions” Compl., Counts I–V. Plaintiffs asks the Court to enjoin CMS “from using the Indiana State Department of Health to conduct further surveys,” and make it mandatory for the Secretary to use the services of other surveyors “independent from the Indiana State Department of Health and CMS.” Compl. at 18, ¶¶ 1(b) & 1(c).

Plaintiffs allege that Defendants Hemmelgarn and Snyder abused the survey process in that they have harassed, discriminated against, intimidated and retaliated against Brar on the basis of race, Plaintiffs’ exercise of First Amendment rights and personal dislike of Brar and/or his companies. Compl. ¶¶ 30–53. Plaintiffs assert the State Defendants “under color of State law, subjected and continue to subject Dr. Brar [and Nightingale] to a deprivation of rights secured by the Constitution and laws of the United States,” Compl. ¶ 61, and that Plaintiffs have suffered and continue to suffer grievous and irreparable harm as a result of such conduct. Compl. ¶ 63. Plaintiffs assert that the State Defendants have violated the Due Process Clause of the Fifth Amendment, the Equal Protection component of the Due Process Clause of the Fifth Amendment, and the First Amendment of the United States Constitution “[b]y ratifying the other Defendants’ actions” Compl., Counts I–V. Plaintiffs seek an injunction to prevent the State Defendants from conducting further surveys, or that the State Defendants may conduct a survey only “in case of a bona fide, third-party complaint alleging facts likely to constitute an immediate threat to the health and well-being of patients.” Compl. at 18, ¶ 1a. Plaintiffs also seek an

order directing the State Defendants to withdraw survey reports they have submitted to CMS since January 1, 2015. Compl. at 18, ¶ 1(d). The Complaint also requests money damages from all Defendants as well as an award of costs and attorneys' fees pursuant to 42 U.S.C. § 1988. Compl. at 18-19, ¶¶ 2 & 3.

II. Standards

Under either Rule 12(b)(1) or 12(b)(6) of the Federal Rules of Civil Procedure ("Rule 12(b)(1) or 12(b)(6)"), the Court must accept as true all well-pleaded factual allegations and draw all reasonable inferences in favor of Plaintiffs. *See Esekiel v. Michel*, 66 F.3d 894, 897 (7th Cir. 1995). Documents central to the Complaint and referred to in it as well as information that is properly the subject of judicial notice may also be considered. *See Williamson v. Curran*, 714 F.3d 432, 436 (7th Cir. 2013) (citing *Geinosky v. City of Chicago*, 675 F.3d 743, 745 n.1 (7th Cir. 2012) (further citation omitted)). Further, the Court "may properly look beyond the jurisdictional allegations of the complaint and view whatever evidence has been submitted on the issue to determine whether in fact subject matter jurisdiction exists." *Esekiel*, 66 F.3d at 897 (quoting *Capitol Leasing Co. v. Fed. Deposit Ins. Corp.*, 999 F.2d 188, 191 (7th Cir. 1993) (per curiam) (further citations omitted)).

Under the Supreme Court's directive in *Bell Atlantic Corp. v. Twombly*, 550 U.S. 544 (2007), to survive Defendants' motions to dismiss for failure to state a claim upon which relief may be granted, Plaintiffs must provide the grounds for their entitlement to relief with more than labels, conclusions or a formulaic recitation of the elements of a cause of ac-

tion. *Id.* at 555 (citing *Papasan v. Allain*, 478 U.S. 265, 286 (1986)). The “allegations must be enough to raise a right to relief above the speculative level.” *Id.* The touchstone is whether the Complaint gives the Defendants “fair notice of what the . . . claim is and the grounds upon which it rests.” *Id.* (quoting *Conley v. Gibson*, 355 U.S. 41, 47 (1957)). Legal conclusions or conclusory allegations are insufficient to state a claim for relief. *McCauley v. City of Chicago*, 671 F.3d 611, 617 (7th Cir. 2011).

III. Discussion

As against the Secretary, Plaintiffs contend that they are seeking only prospective relief for ongoing constitutional violations; therefore, the Court has jurisdiction to entertain their claims. Dkt. No. 26 at 1-2. Specifically, the sovereign immunity defense does not apply to suits for injunctive relief against the Secretary. *Id.* at 2-5 (citing, *inter alia*, *Vance v. Rumsfeld*, 701 F.3d 193, 202 (7th Cir. 2012); *Rose Acre Farms, Inc. v. Madigan*, 956 F.2d 670, 673 (7th Cir. 1992); *Gautreaux v. Romney*, 448 F.2d 731 (7th Cir. 1971); *Ex Parte Young*, 209 U.S. 123 (1908)). Further, there is no “personal participation” requirement in an official capacity claim. *Id.* at 5-7 (citing, *inter alia*, *United States v. Windsor*, 133 S.Ct. 2675 (2013); *Califano v. Westcott*, 443 U.S. 76 (1979); *Bolling v. Sharpe*, 347 U.S. 497 (1954); *Thomas v. Watts*, No. 2:11-cv-00187-JMS-WGH, 2013 WL 3043686 (S.D. In. June 17, 2013)). Finally, Plaintiffs state that their claim against the Secretary is not governed by 42 U.S.C. § 405, because it seeks to enjoin ongoing misconduct by the State Defendants, which they claim the Secretary has the power to stop. *Id.* at 7-10. In fact, Plaintiffs continue, their challenge is “entirely

collateral to its substantive claim of entitlement to participate in the Medicare program,” and the Court has jurisdiction. *Id.* at 8 (quoting *GOS Operator, LLC v. Sebelius*, 843 F.Supp.2d 1218, 1229 (S.D. Ala. 2012); citing *Mathews v. Eldridge*, 424 U.S. 319, 328 (1976)). It is clear, Plaintiffs argue, that they do not seek to recover Medicare reimbursement; therefore, their standing does not turn on provisions of the Medicare Act. *Id.* at 10-11.

As against the State Defendants, Plaintiffs state that they allege unconstitutional targeting and harassment on the basis of Brar’s race or national origin, unlawful targeting and harassment based on personal dislike or other irrational reasons, retaliation for seeking redress of grievances, denial of due process and illegal search of Plaintiffs’ business premises. Dkt. No. 38 at 2 (citing Counts I-V of the Complaint). Further, Plaintiffs similarly argue that the relief they seek is to have independent, rather than ISDH surveyors, perform any future surveys except in cases of a bona fide third party complaint alleging an immediate threat to the health and well-being of patients, for an order that the State Defendants withdraw survey reports submitted to CMS since January 1, 2016 emphasis added), and for money damages for unconstitutional targeting and harassment based on race or national origin and other impermissible reasons. Dkt. No. 38 at 2-3. Plaintiffs claim that they seek only prospective relief and are not challenging the Secretary’s decision, or the underlying reports supporting the decision, to terminate Nightingale’s Medicare status. *Id.* at 3.

The Secretary argues that, notwithstanding Plaintiffs’ attempts to characterize their claims for

relief otherwise, any equitable decision by this Court to change the process for reviewing Plaintiffs' eligibility to participate in Medicare is inextricably intertwined with standards and rights created by and under the Medicare Act; therefore, Plaintiffs' exclusive remedy is under the Act through the appeals process. Dkt. No. 33 at 4-7 (citing, *inter alia*, *Heckler v. Ringer*, 466 U.S. 602 (1984); *Affiliated Prof'l Home Health Care Agency v. Shalala*, 164 F.3d 282, 284 (5th Cir. 1999); *Bodimetric Health Servs., Inc. v. Aetna Life & Cas.*, 903 F.2d 480, 488-89 (7th Cir. 1990)). Moreover, the Secretary asserts that there is no basis through which it would be proper for the Court to circumvent § 405(g) under *Ex Parte Young*. *Id.* at 2-4, 8-13 (citing, *inter alia*, *Shalala v. Ill. Council on Long Term Care, Inc.*, 529 U.S. 1, 10 (2000); *Weinberger v. Salfi*, 422 U.S. 749, 760-61 (1975)).

The State Defendants' argument is similar. First, the State Defendants argue that Plaintiff lack standing because they have failed to allege any injury and to the extent that they have alleged an injury, they must first exhaust their administrative remedies pursuant to Indiana Code § 4-21.5 *et seq.* Dkt. No. 30 at 9-10, 13-14. Second, the State Defendants argue that 42 U.S.C. § 405(h) deprives this Court of subject matter jurisdiction because all claims that "arise under" the Medicare Act must be exhausted under the administrative process before judicial review is appropriate. *Id.* at 11-13. Third, the State Defendants argue that as to Plaintiff Nightingale Home Health Care, Inc., the Court should judicially estop it from bringing any claim because this lawsuit was not listed as an asset on its Bank-

ruptcy Petition. *Id.* at 15-16. Fourth, the State Defendants contend that Plaintiffs have failed to provide sufficient factual basis to hold each of them individually liable. *Id.* at 16-18. Finally, the State Defendants challenge the sufficiency of the allegations as to Counts I, Equal Protection; IV, Procedural Due Process; and V, Unlawful Search and Seizure. *Id.* at 18-21.

The Court agrees with the Secretary and the State Defendants that the relief sought by Plaintiffs in this case must be subject to exhaustion under § 405(h). In the first instance, Plaintiffs cannot and do not deny that the relief they seek is to change the review procedure used for their facilities. It is clear that this review and oversight process is set forth in the Act and regulations promulgated by the Secretary under the Act and even provides for instances in which the Secretary may use a service other than CMS and a state agency. *See* 42 U.S.C. §§ 1395x(m), 1395x(o), 1395bbb, 1395aa(a), 1395bb, 1395aa(c), & 1395cc(b); 42 C.F.R. §§ 488.6, 488.7, 488.8, 488.10, 488.11, 488.12, 488.20, 498.3, 498.40, 498.80 & 498.90. In a case that challenges the procedures undertaken by the Secretary with respect to regulation of a Medicare provider, 42 U.S.C. § 1395ii channels all claims arising under the Act to an administrative process exclusively: “No findings of fact or decision of the [Secretary] shall be reviewed by any person, tribunal or governmental agency except as herein provided;” and “[n]o action against [the Secretary] shall be brought under section 1331 or 1346 of title 28 to recover on any claim arising under this subchapter.” 42 U.S.C. § 405(h). That Plaintiffs have claimed that their Constitutional rights have been

violated does not change the analysis because the Secretary has the authority to review such a challenge. Accord *Ill. Council*, 529 U.S. at 13-14 (concluding that a certain nursing homes' challenge to provisions of the Medicare Act as unconstitutional are subject to the administrative procedure in § 405(h)); *Salfi*, 422 U.S. at 761 (concluding that allegations of due process and equal protection violations in the Social Security context could not proceed under § 1331); *Ringer*, 466 U.S. at 614-15, 621-22 (concluding that § 405(h) applies where "both the standing and the substantive basis for the presentation" of the claim is the Medicare Act). Moreover, the relief Plaintiffs seek in the Complaint is withdrawal of several surveys that formed the basis for termination of their status. As such, their claims must first be addressed through the administrative process.

Even if the challenge is prospective as Plaintiffs argue, this Court will not be able to make a determination as to the merits unless it looks at the past and current decisions by the State Defendants under the auspices of the Medicare Act. As a result, any allegedly unrelated issues are inextricably intertwined with and un-severable from the Act. Plaintiffs seek to have the Court order the Secretary to proceed with her duties under the Medicare Act in a certain manner; therefore, any determination must arise under the Act; therefore, Plaintiffs must first exhaust their administrative remedies under § 405(h). See *Ringer* 466 U.S. at 615-16.

Plaintiffs' reliance on *Ex Parte Young* with respect to the Secretary is also misplaced. There is no evidence that Plaintiffs are left with no options. In fact, they are challenging the Secretary's decision in two

forums. Under this circumstance, the Court will not apply the *Ex Parte Young* doctrine. *Accord Armstrong v. Exceptional Child Ctr., Inc.*, ___ U.S. ___, 135 S.Ct. 1378, 1387, 191 L.Ed.2d 471 (2015).

Furthermore, with respect to the individual State Defendants, the barebones allegations of racial discrimination in the Complaint is insufficient under *Iqbal*, 556 U.S. at 678. For example, there are no factual allegations that other providers of any race have been treated differently by any of the Defendants; nor are there any facts from which the State Defendants can determine on which date negative survey results were racially motivated. Similarly, there is no factual support for the proposition that the number of survey's performed at Plaintiffs' facilities were excessive or in any other way discriminatory because no numbers are provided for Plaintiffs' facilities or any other similarly situated facility. In the same vein, there are no facts from which to conclude that the State Defendants impermissibly entered Plaintiffs' hospice facility to perform an inspection pursuant to state law. *See* Ind. Code §§ 16-25-3-6 (initial survey for licensure); 16-25-5-4 (complaint survey); 25-5-2.5 (minimum survey requirements); 16-25-5-5 (investigation of unlicensed hospice).

Moreover, with respect to Nightingale's assertion that the State Defendants have "ignored and violated required procedures for Medicare surveys" that deprived Plaintiffs of some liberty or property interest in their Medicare status in violation of the due process clause of the Fourteenth Amendment, Compl. ¶ 75, the Court agrees with the State Defendants that, to the extent such a liberty or property interest exists, the administrative review process

provides Plaintiffs a remedy and they are not entitled to a pre-determination hearing. *See Bryn Mawr Care, Inc. v. Sebelius*, 749 F.3d 592, 603 (7th Cir. 2014); *Northlake Cmty. Hosp. v. United States*, 654 F.2d 1234, 1242 (7th Cir. 1981).

IV. Conclusion

For the reasons stated herein, the Court GRANTS Defendants', Kelly Hemmelgarn, Randall Snyder, Ingrid Miller, Sylvia Mathews Burwell, and Jerome Adams, Motions to Dismiss. The Court has determined that it is without jurisdiction to hear Plaintiffs' claims; therefore, the dismissal is with prejudice and judgment will be entered accordingly.

IT IS SO ORDERED this 5th day of April, 2016.

/s/ Larry McKinney
Judge,
United States District Court
Southern District of Indiana

ORDER OF THE SEVENTH CIRCUIT DENYING
PETITION FOR REHEARING EN BANC
(AUGUST 22, 2017)

UNITED STATES COURT OF APPEALS
FOR THE SEVENTH CIRCUIT

HOME CARE PROVIDERS, INC., ET AL.,

Plaintiffs-Appellants,

v.

KELLY HEMMELGARN, ET AL.,

Defendants-Appellees.

Nos. 16-2054

Appeals from the United States District Court for the
Southern District of Indiana, Indianapolis Division.

Nos. 1:16-cv-00303 Larry J. McKinney, Judge.

Before: William J. BAUER, Joel M. FLAUM, and
Michael S. KANNE, Circuit Judges.

On July 11, 2017, plaintiff-appellants filed a petition for *en banc* rehearing in connection with the above-referenced case. On August 10, 2017, an Answer was filed by the defendant-appellees to the petition for rehearing *en banc*. No judge in active service has requested a vote on the petition for rehearing *en banc*, and all of the judges on the original panel have voted to deny the petition for rehearing. The petition for rehearing is therefore DENIED.

RELEVANT STATUTORY PROVISIONS

42 U.S.C. § 405—Evidence, Procedure, and Certification for Payments

(a) Rules and Regulations; Procedures

The Commissioner of Social Security shall have full power and authority to make rules and regulations and to establish procedures, not inconsistent with the provisions of this subchapter, which are necessary or appropriate to carry out such provisions, and shall adopt reasonable and proper rules and regulations to regulate and provide for the nature and extent of the proofs and evidence and the method of taking and furnishing the same in order to establish the right to benefits hereunder.

(b) Administrative Determination of Entitlement to Benefits; Findings of Fact; Hearings; Investigations; Evidentiary Hearings in Reconsiderations of Disability Benefit Terminations; Subsequent Applications

(1) The Commissioner of Social Security is directed to make findings of fact, and decisions as to the rights of any individual applying for a payment under this subchapter. Any such decision by the Commissioner of Social Security which involves a determination of disability and which is in whole or in part unfavorable to such individual shall contain a statement of the case, in understandable language, setting forth a discussion of the evidence, and stating the Commissioner's determination and the reason or reasons upon which it is based. Upon request by any such individual or upon request by a wife, divorced

wife, widow, surviving divorced wife, surviving divorced mother, surviving divorced father, husband, divorced husband, widower, surviving divorced husband, child, or parent who makes a showing in writing that his or her rights may be prejudiced by any decision the Commissioner of Social Security has rendered, the Commissioner shall give such applicant and such other individual reasonable notice and opportunity for a hearing with respect to such decision, and, if a hearing is held, shall, on the basis of evidence adduced at the hearing, affirm, modify, or reverse the Commissioner's findings of fact and such decision. Any such request with respect to such a decision must be filed within sixty days after notice of such decision is received by the individual making such request. The Commissioner of Social Security is further authorized, on the Commissioner's own motion, to hold such hearings and to conduct such investigations and other proceedings as the Commissioner may deem necessary or proper for the administration of this subchapter. In the course of any hearing, investigation, or other proceeding, the Commissioner may administer oaths and affirmations, examine witnesses, and receive evidence. Evidence may be received at any hearing before the Commissioner of Social Security even though inadmissible under rules of evidence applicable to court procedure.

(2) In any case where—

(A) an individual is a recipient of disability insurance benefits, or of child's, widow's, or widower's insurance benefits based on disability,

(B) the physical or mental impairment on the basis of which such benefits are payable is found

to have ceased, not to have existed, or to no longer be disabling, and

(C) as a consequence of the finding described in subparagraph (B), such individual is determined by the Commissioner of Social Security not to be entitled to such benefits,

any reconsideration of the finding described in subparagraph (B), in connection with a reconsideration by the Commissioner of Social Security (before any hearing under paragraph (1) on the issue of such entitlement) of the Commissioner's determination described in subparagraph (C), shall be made only after opportunity for an evidentiary hearing, with regard to the finding described in subparagraph (B), which is reasonably accessible to such individual. Any reconsideration of a finding described in subparagraph (B) may be made either by the State agency or the Commissioner of Social Security where the finding was originally made by the State agency, and shall be made by the Commissioner of Social Security where the finding was originally made by the Commissioner of Social Security. In the case of a reconsideration by a State agency of a finding described in subparagraph (B) which was originally made by such State agency, the evidentiary hearing shall be held by an adjudicatory unit of the State agency other than the unit that made the finding described in subparagraph (B). In the case of a reconsideration by the Commissioner of Social Security of a finding described in subparagraph (B) which was originally made by the Commissioner of Social Security, the evidentiary hearing

shall be held by a person other than the person or persons who made the finding described in subparagraph (B).

(3)

(A) A failure to timely request review of an initial adverse determination with respect to an application for any benefit under this subchapter or an adverse determination on reconsideration of such an initial determination shall not serve as a basis for denial of a subsequent application for any benefit under this subchapter if the applicant demonstrates that the applicant, or any other individual referred to in paragraph (1), failed to so request such a review acting in good faith reliance upon incorrect, incomplete, or misleading information, relating to the consequences of reapplying for benefits in lieu of seeking review of an adverse determination, provided by any officer or employee of the Social Security Administration or any State agency acting under section 421 of this title.

(B) In any notice of an adverse determination with respect to which a review may be requested under paragraph (1), the Commissioner of Social Security shall describe in clear and specific language the effect on possible entitlement to benefits under this subchapter of choosing to reapply in lieu of requesting review of the determination.

(c) Wage Records

(1) For the purposes of this subsection—

- (A) The term “year” means a calendar year when used with respect to wages and a taxable year when used with respect to self-employment income.
- (B) The term “time limitation” means a period of three years, three months, and fifteen days.
- (C) The term “survivor” means an individual’s spouse, surviving divorced wife, surviving divorced husband, surviving divorced mother, surviving divorced father, child, or parent, who survives such individual.
- (D) The term “period” when used with respect to self-employment income means a taxable year and when used with respect to wages means—
 - (i) a quarter if wages were reported or should have been reported on a quarterly basis on tax returns filed with the Secretary of the Treasury or his delegate under section 6011 the Internal Revenue Code of 1986 [Title 26, U.S.C.A.] or regulations thereunder (or on reports filed by a State under section 418(e) of this title (as in effect prior to December 31, 1986) or regulations thereunder),
 - (ii) a year if wages were reported or should have been reported on a yearly basis on such tax returns or reports, or
 - (iii) the half year beginning January 1 or July 1 in the case of wages which were reported or should have been reported for calendar year 1937.

(2)

(A) On the basis of information obtained by or submitted to the Commissioner of Social Security, and after such verification thereof as the Commissioner deems necessary, the Commissioner of Social Security shall establish and maintain records of the amounts of wages paid to, and the amounts of self-employment income derived by, each individual and of the periods in which such wages were paid and such income was derived and, upon request, shall inform any individual or his survivor, or the legal representative of such individual or his estate, of the amounts of wages and self-employment income of such individual and the periods during which such wages were paid and such income was derived, as shown by such records at the time of such request.

(B)

(i) In carrying out the Commissioner's duties under subparagraph (A) and subparagraph (F), the Commissioner of Social Security shall take affirmative measures to assure that social security account numbers will, to the maximum extent practicable, be assigned to all members of appropriate groups or categories of individuals by assigning such numbers (or ascertaining that such numbers have already been assigned):

(I) to aliens at the time of their lawful admission to the United States either for permanent residence or under other authority of law permitting them to

engage in employment in the United States and to other aliens at such time as their status is so changed as to make it lawful for them to engage in such employment;

- (II) to any individual who is an applicant for or recipient of benefits under any program financed in whole or in part from Federal funds including any child on whose behalf such benefits are claimed by another person; and
- (III) to any other individual when it appears that he could have been but was not assigned an account number under the provisions of subclauses (I) or (II) but only after such investigation as is necessary to establish to the satisfaction of the Commissioner of Social Security, the identity of such individual, the fact that an account number has not already been assigned to such individual, and the fact that such individual is a citizen or a noncitizen who is not, because of his alien status, prohibited from engaging in employment;

and, in carrying out such duties, the Commissioner of Social Security is authorized to take affirmative measures to assure the issuance of social security numbers:

- (IV) to or on behalf of children who are below school age at the request of their parents or guardians; and

- (V) to children of school age at the time of their first enrollment in school.
 - (ii) The Commissioner of Social Security shall require of applicants for social security account numbers such evidence as may be necessary to establish the age, citizenship, or alien status, and true identity of such applicants, and to determine which (if any) social security account number has previously been assigned to such individual. With respect to an application for a social security account number for an individual who has not attained the age of 18 before such application, such evidence shall include the information described in subparagraph (C)(ii).
 - (iii) In carrying out the requirements of this subparagraph, the Commissioner of Social Security shall enter into such agreements as may be necessary with the Attorney General and other officials and with State and local welfare agencies and school authorities (including nonpublic school authorities).
- (C)
- (i) It is the policy of the United States that any State (or political subdivision thereof) may, in the administration of any tax, general public assistance, driver's license, or motor vehicle registration law within its jurisdiction, utilize the social security account numbers issued by the Commissioner of Social Security for the purpose of establishing the identification of individuals

affected by such law, and may require any individual who is or appears to be so affected to furnish to such State (or political subdivision thereof) or any agency thereof having administrative responsibility for the law involved, the social security account number (or numbers, if he has more than one such number) issued to him by the Commissioner of Social Security.

- (ii) In the administration of any law involving the issuance of a birth certificate, each State shall require each parent to furnish to such State (or political subdivision thereof) or any agency thereof having administrative responsibility for the law involved, the social security account number (or numbers, if the parent has more than one such number) issued to the parent unless the State (in accordance with regulations prescribed by the Commissioner of Social Security) finds good cause for not requiring the furnishing of such number. The State shall make numbers furnished under this subclause available to the Commissioner of Social Security and the agency administering the State's plan under part D of subchapter IV of this chapter in accordance with Federal or State law and regulation. Such numbers shall not be recorded on the birth certificate. A State shall not use any social security account number, obtained with respect to the issuance by the State of a birth certificate, for any purpose other than for the enforcement of child support orders in effect

in the State, unless section 7(a) of the Privacy Act of 1974 does not prohibit the State from requiring the disclosure of such number, by reason of the State having adopted, before January 1, 1975, a statute or regulation requiring such disclosure.

(iii)

- (I) In the administration of section 9 of the Food and Nutrition Act of 2008 (7 U.S.C. 2018) involving the determination of the qualifications of applicants under such Act [7 U.S.C.A. § 2011 et seq.], the Secretary of Agriculture may require each applicant retail store or wholesale food concern to furnish to the Secretary of Agriculture the social security account number of each individual who is an officer of the store or concern and, in the case of a privately owned applicant, furnish the social security account numbers of the owners of such applicant. No officer or employee of the Department of Agriculture shall have access to any such number for any purpose other than the establishment and maintenance of a list of the names and social security account numbers of such individuals for use in determining those applicants who have been previously sanctioned or convicted under section 12 or 15 of such Act (7 U.S.C. 2021 or 2024).
- (II) The Secretary of Agriculture may share any information contained in any list

referred to in subclause (I) with any other agency or instrumentality of the United States which otherwise has access to social security account numbers in accordance with this subsection or other applicable Federal law, except that the Secretary of Agriculture may share such information only to the extent that such Secretary determines such sharing would assist in verifying and matching such information against information maintained by such other agency or instrumentality. Any such information shared pursuant to this subclause may be used by such other agency or instrumentality only for the purpose of effective administration and enforcement of the Food and Nutrition Act of 2008 [7 U.S.C.A. § 2011 et seq.] or for the purpose of investigation of violations of other Federal laws or enforcement of such laws.

- (III) The Secretary of Agriculture, and the head of any other agency or instrumentality referred to in this subclause, shall restrict, to the satisfaction of the Commissioner of Social Security, access to social security account numbers obtained pursuant to this clause only to officers and employees of the United States whose duties or responsibilities require access for the purposes described in subclause (II).

- (IV) The Secretary of Agriculture, and the head of any agency or instrumentality with which information is shared pursuant to clause (II), shall provide such other safeguards as the Commissioner of Social Security determines to be necessary or appropriate to protect the confidentiality of the social security account numbers.
- (iv) In the administration of section 506 of the Federal Crop Insurance Act [7 U.S.C.A. § 1506], the Federal Crop Insurance Corporation may require each policyholder and each reinsured company to furnish to the insurer or to the Corporation the social security account number of such policyholder, subject to the requirements of this clause. No officer or employee of the Federal Crop Insurance Corporation shall have access to any such number for any purpose other than the establishment of a system of records necessary for the effective administration of such Act [7 U.S.C.A. § 1501 et seq.]. The Manager of the Corporation may require each policyholder to provide to the Manager, at such times and in such manner as prescribed by the Manager, the social security account number of each individual that holds or acquires a substantial beneficial interest in the policyholder. For purposes of this clause, the term “substantial beneficial interest” means not less than 5 percent of all beneficial interest in the policyholder. The Secretary of Agriculture shall restrict,

to the satisfaction of the Commissioner of Social Security, access to social security account numbers obtained pursuant to this clause only to officers and employees of the United States or authorized persons whose duties or responsibilities require access for the administration of the Federal Crop Insurance Act. The Secretary of Agriculture shall provide such other safeguards as the Commissioner of Social Security determines to be necessary or appropriate to protect the confidentiality of such social security account numbers. For purposes of this clause the term “authorized person” means an officer or employee of an insurer whom the Manager of the Corporation designates by rule, subject to appropriate safeguards including a prohibition against the release of such social security account number (other than to the Corporation) by such person.

- (v) If and to the extent that any provision of Federal law heretofore enacted is inconsistent with the policy set forth in clause (i), such provision shall, on and after October 4, 1976, be null, void, and of no effect. If and to the extent that any such provision is inconsistent with the requirement set forth in clause (ii), such provision shall, on and after October 13, 1988, be null, void, and of no effect.
- (vi)
 - (I) For purposes of clause (i) of this subparagraph, an agency of a State (or

political subdivision thereof) charged with the administration of any general public assistance, driver's license, or motor vehicle registration law which did not use the social security account number for identification under a law or regulation adopted before January 1, 1975, may require an individual to disclose his or her social security number to such agency solely for the purpose of administering the laws referred to in clause (i) above and for the purpose of responding to requests for information from an agency administering a program funded under part A of subchapter IV of this chapter or an agency operating pursuant to the provisions of part D of such subchapter.

- (II) Any State or political subdivision thereof (and any person acting as an agent of such an agency or instrumentality), in the administration of any driver's license or motor vehicle registration law within its jurisdiction, may not display a social security account number issued by the Commissioner of Social Security (or any derivative of such number) on any driver's license, motor vehicle registration, or personal identification card (as defined in section 7212(a)(2) of the 9/11 Commission Implementation Act of 2004), or include, on any such license, registration, or personal identification card, a magnetic

strip, bar code, or other means of communication which conveys such number (or derivative thereof).

(vii) For purposes of this subparagraph, the term “State” includes the District of Columbia, the Commonwealth of Puerto Rico, the Virgin Islands, Guam, the Commonwealth of the Northern Marianas, and the Trust Territory of the Pacific Islands.

(viii)

(I) Social security account numbers and related records that are obtained or maintained by authorized persons pursuant to any provision of law enacted on or after October 1, 1990, shall be confidential, and no authorized person shall disclose any such social security account number or related record.

(II) Paragraphs (1), (2), and (3) of section 7213(a) of the Internal Revenue Code of 1986 shall apply with respect to the unauthorized willful disclosure to any person of social security account numbers and related records obtained or maintained by an authorized person pursuant to a provision of law enacted on or after October 1, 1990, in the same manner and to the same extent as such paragraphs apply with respect to unauthorized disclosures of return and return information described in such paragraphs. Paragraph (4) of section 7213(a) of such Code shall apply with

respect to the willful offer of any item of material value in exchange for any such social security account number or related record in the same manner and to the same extent as such paragraph applies with respect to offers (in exchange for any return or return information) described in such paragraph.

- (III) For purposes of this clause, the term “authorized person” means an officer or employee of the United States, an officer or employee of any State, political subdivision of a State, or agency of a State or political subdivision of a State, and any other person (or officer or employee thereof), who has or had access to social security account numbers or related records pursuant to any provision of law enacted on or after October 1, 1990. For purposes of this subclause, the term “officer or employee” includes a former officer or employee.
- (IV) For purposes of this clause, the term “related record” means any record, list, or compilation that indicates, directly or indirectly, the identity of any individual with respect to whom a social security account number or a request for a social security account number is maintained pursuant to this clause.
- (ix) In the administration of the provisions of chapter 81 of Title 5 and the Longshore and Harbor Workers’ Compensation Act (33 U.S.C. 901 et seq.), the Secretary of Labor

may require by regulation that any person filing a notice of injury or a claim for benefits under such provisions provide as part of such notice or claim such person's social security account number, subject to the requirements of this clause. No officer or employee of the Department of Labor shall have access to any such number for any purpose other than the establishment of a system of records necessary for the effective administration of such provisions. The Secretary of Labor shall restrict, to the satisfaction of the Commissioner of Social Security, access to social security account numbers obtained pursuant to this clause to officers and employees of the United States whose duties or responsibilities require access for the administration or enforcement of such provisions. The Secretary of Labor shall provide such other safeguards as the Commissioner of Social Security determines to be necessary or appropriate to protect the confidentiality of the social security account numbers.

- (x) The Secretary of Health and Human Services, and the Exchanges established under section 1311 of the Patient Protection and Affordable Care Act, are authorized to collect and use the names and social security account numbers of individuals as required to administer the provisions of, and the amendments made by, the such Act.
- (xi) No Federal, State, or local agency may display the Social Security account number

of any individual, or any derivative of such number, on any check issued for any payment by the Federal, State, or local agency.

- (xii) No Federal, State, or local agency may employ, or enter into a contract for the use or employment of, prisoners in any capacity that would allow such prisoners access to the Social Security account numbers of other individuals. For purposes of this clause, the term “prisoner” means an individual confined in a jail, prison, or other penal institution or correctional facility pursuant to such individual’s conviction of a criminal offense.
 - (xiii) The Secretary of Health and Human Services, in consultation with the Commissioner of Social Security, shall establish cost-effective procedures to ensure that a Social Security account number (or derivative thereof) is not displayed, coded, or embedded on the Medicare card issued to an individual who is entitled to benefits under part A of subchapter XVIII or enrolled under part B of subchapter XVIII and that any other identifier displayed on such card is not identifiable as a Social Security account number (or derivative thereof).
- (D)
- (i) It is the policy of the United States that—
 - (I) any State (or any political subdivision of a State) and any authorized blood donation facility may utilize the social security account numbers issued by the

Commissioner of Social Security for the purpose of identifying blood donors, and

- (II) any State (or political subdivision of a State) may require any individual who donates blood within such State (or political subdivision) to furnish to such State (or political subdivision), to any agency thereof having related administrative responsibility, or to any authorized blood donation facility the social security account number (or numbers, if the donor has more than one such number) issued to the donor by the Commissioner of Social Security.
- (ii) If and to the extent that any provision of Federal law enacted before November 10, 1988, is inconsistent with the policy set forth in clause (i), such provision shall, on and after November 10, 1988, be null, void, and of no effect.
- (iii) For purposes of this subparagraph—
 - (I) the term “authorized blood donation facility” means an entity described in section 1320b-11(h)(1)(B) of this title, and
 - (II) the term “State” includes the District of Columbia, the Commonwealth of Puerto Rico, the Virgin Islands, Guam, the Commonwealth of the Northern Marianas, and the Trust Territory of the Pacific Islands.

(E)

- (i) It is the policy of the United States that—
 - (I) any State (or any political subdivision of a State) may utilize the social security account numbers issued by the Commissioner of Social Security for the additional purposes described in clause (ii) if such numbers have been collected and are otherwise utilized by such State (or political subdivision) in accordance with applicable law, and
 - (II) any district court of the United States may use, for such additional purposes, any such social security account numbers which have been so collected and are so utilized by any State.
- (ii) The additional purposes described in this clause are the following:
 - (I) Identifying duplicate names of individuals on master lists used for jury selection purposes.
 - (II) Identifying on such master lists those individuals who are ineligible to serve on a jury by reason of their conviction of a felony.
- (iii) To the extent that any provision of Federal law enacted before August 15, 1994, is inconsistent with the policy set forth in clause (i), such provision shall, on and after August 15, 1994, be null, void, and of no effect.

(iv) For purposes of this subparagraph, the term “State” has the meaning such term has in subparagraph (D).

(F) The Commissioner of Social Security shall require, as a condition for receipt of benefits under this subchapter, that an individual furnish satisfactory proof of a social security account number assigned to such individual by the Commissioner of Social Security or, in the case of an individual to whom no such number has been assigned, that such individual make proper application for assignment of such a number.

(G) The Commissioner of Social Security shall issue a social security card to each individual at the time of the issuance of a social security account number to such individual. The social security card shall be made of banknote paper, and (to the maximum extent practicable) shall be a card which cannot be counterfeited.

(H) The Commissioner of Social Security shall share with the Secretary of the Treasury the information obtained by the Commissioner pursuant to the second sentence of subparagraph (B)(ii) and to subparagraph (C)(ii) for the purpose of administering those sections of the Internal Revenue Code of 1986 which grant tax benefits based on support or residence of children.

(3) The Commissioner’s records shall be evidence for the purpose of proceedings before the Commissioner of Social Security or any court of the amounts of wages paid to, and self-employment income derived by, an individual and of the periods in which such wages were paid and such income was derived. The

absence of an entry in such records as to wages alleged to have been paid to, or as to self-employment income alleged to have been derived by, an individual in any period shall be evidence that no such alleged wages were paid to, or that no such alleged income was derived by, such individual during such period.

(4) Prior to the expiration of the time limitation following any year the Commissioner of Social Security may, if it is brought to the Commissioner's attention that any entry of wages or self-employment income in the Commissioner's records for such year is erroneous or that any item of wages or self-employment income for such year has been omitted from such records, correct such entry or include such omitted item in the Commissioner's records, as the case may be. After the expiration of the time limitation following any year—

(A) the Commissioner's records (with changes, if any, made pursuant to paragraph (5) of this subsection) of the amounts of wages paid to, and self-employment income derived by, an individual during any period in such year shall be conclusive for the purposes of this subchapter;

(B) the absence of an entry in the Commissioner's records as to the wages alleged to have been paid by an employer to an individual during any period in such year shall be presumptive evidence for the purposes of this subchapter that no such alleged wages were paid to such individual in such period; and

(C) the absence of an entry in the Commissioner's records as to the self-employment income alleged to have been derived by an individual in such

year shall be conclusive for the purposes of this subchapter that no such alleged self-employment income was derived by such individual in such year unless it is shown that he filed a tax return of his self-employment income for such year before the expiration of the time limitation following such year, in which case the Commissioner of Social Security shall include in the Commissioner's records the self-employment income of such individual for such year.

(5) After the expiration of the time limitation following any year in which wages were paid or alleged to have been paid to, or self-employment income was derived or alleged to have been derived by, an individual, the Commissioner of Social Security may change or delete any entry with respect to wages or self-employment income in the Commissioner's records of such year for such individual or include in the Commissioner's records of such year for such individual any omitted item of wages or self-employment income but only—

(A) if an application for monthly benefits or for a lump-sum death payment was filed within the time limitation following such year; except that no such change, deletion, or inclusion may be made pursuant to this subparagraph after a final decision upon the application for monthly benefits or lump-sum death payment;

(B) if within the time limitation following such year an individual or his survivor makes a request for a change or deletion, or for an inclusion of an omitted item, and alleges in writing that the Commissioner's records of the wages paid to, or the self-employment income

derived by, such individual in such year are in one or more respects erroneous; except that no such change, deletion, or inclusion may be made pursuant to this subparagraph after a final decision upon such request. Written notice of the Commissioner's decision on any such request shall be given to the individual who made the request;

(C) to correct errors apparent on the face of such records;

(D) to transfer items to records of the Railroad Retirement Board if such items were credited under this subchapter when they should have been credited under the Railroad Retirement Act of 1937 or 1974 [45 U.S.C.A. § 228a et seq., § 231 et seq.], or to enter items transferred by the Railroad Retirement Board which have been credited under the Railroad Retirement Act of 1937 or 1974 when they should have been credited under this subchapter;

(E) to delete or reduce the amount of any entry which is erroneous as a result of fraud;

(F) to conform the Commissioner's records to—

(i) tax returns or portions thereof (including information returns and other written statements) filed with the Commissioner of Internal Revenue under Title VIII of the Social Security Act under subchapter E of chapter 1 or subchapter A of chapter 9 of the Internal Revenue Code of 1939, under chapter 2 or 21 of the Internal Revenue Code of 1954 or the Internal Revenue Code

of 1986, or under regulations made under authority of such title, subchapter, or chapter;

- (ii) wage reports filed by a State pursuant to an agreement under section 418 of this title or regulations of the Commissioner of Social Security thereunder; or
- (iii) assessments of amounts due under an agreement pursuant to section 418 of this title (as in effect prior to December 31, 1986), if such assessments are made within the period specified in subsection (q) of such section (as so in effect), or allowances of credits or refunds of overpayments by a State under an agreement pursuant to such section;

except that no amount of self-employment income of an individual for any taxable year (if such return or statement was filed after the expiration of the time limitation following the taxable year) shall be included in the Commissioner's records pursuant to this subparagraph;

- (G) to correct errors made in the allocation, to individuals or periods, of wages or self-employment income entered in the records of the Commissioner of Social Security;
- (H) to include wages paid during any period in such year to an individual by an employer;
- (I) to enter items which constitute remuneration for employment under subsection (o) of this section, such entries to be in accordance with certi-

fied reports of records made by the Railroad Retirement Board pursuant to section 5(k)(3) of the Railroad Retirement Act of 1937 [45 U.S.C.A. § 228e(k)(3)] or section 7(b)(7) of the Railroad Retirement Act of 1974 [45 U.S.C.A. § 231f(b)(7)]; or

(J) to include self-employment income for any taxable year, up to, but not in excess of, the amount of wages deleted by the Commissioner of Social Security as payments erroneously included in such records as wages paid to such individual, if such income (or net earnings from self-employment), not already included in such records as self-employment income, is included in a return or statement (referred to in subparagraph (F) of this subsection) filed before the expiration of the time limitation following the taxable year in which such deletion of wages is made.

(6) Written notice of any deletion or reduction under paragraph (4) or (5) of this subsection shall be given to the individual whose record is involved or to his survivor, except that (A) in the case of a deletion or reduction with respect to any entry of wages such notice shall be given to such individual only if he has previously been notified by the Commissioner of Social Security of the amount of his wages for the period involved, and (B) such notice shall be given to such survivor only if he or the individual whose record is involved has previously been notified by the Commissioner of Social Security of the amount of such individual's wages and self-employment income for the period involved.

(7) Upon request in writing (within such period, after any change or refusal of a request for a change

of the Commissioner's records pursuant to this subsection, as the Commissioner of Social Security may prescribe), opportunity for hearing with respect to such change or refusal shall be afforded to any individual or his survivor. If a hearing is held pursuant to this paragraph the Commissioner of Social Security shall make findings of fact and a decision based upon the evidence adduced at such hearing and shall include any omitted items, or change or delete any entry, in the Commissioner's records as may be required by such findings and decision.

(8) A translation into English by a third party of a statement made in a foreign language by an applicant for or beneficiary of monthly insurance benefits under this subchapter shall not be regarded as reliable for any purpose under this subchapter unless the third party, under penalty of perjury—

(A) certifies that the translation is accurate; and

(B) discloses the nature and scope of the relationship between the third party and the applicant or recipient, as the case may be.

(9) Decisions of the Commissioner of Social Security under this subsection shall be reviewable by commencing a civil action in the United States district court as provided in subsection (g) of this section.

(d) Issuance of Subpoenas in Administrative Proceedings

For the purpose of any hearing, investigation, or other proceeding authorized or directed under this subchapter, or relative to any other matter within the Commissioner's jurisdiction hereunder, the Com-

missioner of Social Security shall have power to issue subpoenas requiring the attendance and testimony of witnesses and the production of any evidence that relates to any matter under investigation or in question before the Commissioner of Social Security. Such attendance of witnesses and production of evidence at the designated place of such hearing, investigation, or other proceeding may be required from any place in the United States or in any Territory or possession thereof. Subpoenas of the Commissioner of Social Security shall be served by anyone authorized by the Commissioner (1) by delivering a copy thereof to the individual named therein, or (2) by registered mail or by certified mail addressed to such individual at his last dwelling place or principal place of business. A verified return by the individual so serving the subpoena setting forth the manner of service, or, in the case of service by registered mail or by certified mail, the return post-office receipt therefor signed by the individual so served, shall be proof of service. Witnesses so subpoenaed shall be paid the same fees and mileage as are paid witnesses in the district courts of the United States.

(e) Judicial Enforcement of Subpoenas; Contempt

In case of contumacy by, or refusal to obey a subpoena duly served upon, any person, any district court of the United States for the judicial district in which said person charged with contumacy or refusal to obey is found or resides or transacts business, upon application by the Commissioner of Social Security, shall have jurisdiction to issue an order requiring such person to appear and give testimony, or to appear and produce evidence, or both; any fail-

ure to obey such order of the court may be punished by said court as contempt thereof.

(f) Repealed. Pub.L. 91-452, Title II, § 236, Oct. 15, 1970, 84 Stat. 930

(g) Judicial Review

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

to an individual who was a party to the hearing before the Commissioner of Social Security, because of failure of the claimant or such individual to submit proof in conformity with any regulation prescribed under subsection (a) of this section, the court shall review only the question of conformity with such regulations and the validity of such regulations. The court may, on motion of the Commissioner of Social Security made for good cause shown before the Commissioner files the Commissioner's answer, remand the case to the Commissioner of Social Security for further action by the Commissioner of Social Security, and it may at any time order additional evidence to be taken before the Commissioner of Social Security, but only upon a showing that there is new evidence which is material and that there is good cause for the failure to incorporate such evidence into the record in a prior proceeding; and the Commissioner of Social Security shall, after the case is remanded, and after hearing such additional evidence if so ordered, modify or affirm the Commissioner's findings of fact or the Commissioner's decision, or both, and shall file with the court any such additional and modified findings of fact and decision, and, in any case in which the Commissioner has not made a decision fully favorable to the individual, a transcript of the additional record and testimony upon which the Commissioner's action in modifying or affirming was based. Such additional or modified findings of fact and decision shall be reviewable only to the extent provided for review of the original findings of fact and decision. The judgment of the court shall be final except that it shall be subject to review in the same manner as a judgment in other civil actions. Any action instituted in accordance with this subsection

shall survive notwithstanding any change in the person occupying the office of Commissioner of Social Security or any vacancy in such office.

(h) Finality of Commissioner's Decision

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

(i) Certification for Payment

Upon final decision of the Commissioner of Social Security, or upon final judgment of any court of competent jurisdiction, that any person is entitled to any payment or payments under this subchapter, the Commissioner of Social Security shall certify to the Managing Trustee the name and address of the person so entitled to receive such payment or payments, the amount of such payment or payments, and the time at which such payment or payments should be made, and the Managing Trustee, through the Fiscal Service of the Department of the Treasury, and prior to any action thereon by the Government Accountability Office, shall make payment in accordance with the certification of the Commissioner of Social Security (except that in the case of (A) an individual who will have completed ten years of service

(or five or more years of service, all of which accrues after December 31, 1995) creditable under the Railroad Retirement Act of 1937 [45 U.S.C.A. § 228a et seq.] or the Railroad Retirement Act of 1974 [45 U.S.C.A. § 231 et seq.], (B) the wife or husband or divorced wife or divorced husband of such an individual, (C) any survivor of such an individual if such survivor is entitled, or could upon application become entitled, to an annuity under section 2 of the Railroad Retirement Act of 1974 [45 U.S.C.A. § 231a], and (D) any other person entitled to benefits under section 402 of this title on the basis of the wages and self-employment income of such an individual (except a survivor of such an individual where such individual did not have a current connection with the railroad industry, as defined in the Railroad Retirement Act of 1974, at the time of his death), such certification shall be made to the Railroad Retirement Board which shall provide for such payment or payments to such person on behalf of the Managing Trustee in accordance with the provisions of the Railroad Retirement Act of 1974): Provided, That where a review of the Commissioner's decision is or may be sought under subsection (g) of this section the Commissioner of Social Security may withhold certification of payment pending such review. The Managing Trustee shall not be held personally liable for any payment or payments made in accordance with a certification by the Commissioner of Social Security.

(j) Representative Payees

(1)

(A) If the Commissioner of Social Security determines that the interest of any individual under this subchapter would be served thereby, certification of payment of such individual's benefit under this subchapter may be made, regardless of the legal competency or incompetency of the individual, either for direct payment to the individual, or for his or her use and benefit, to another individual, or an organization, with respect to whom the requirements of paragraph (2) have been met (hereinafter in this subsection referred to as the individual's "representative payee"). If the Commissioner of Social Security or a court of competent jurisdiction determines that a representative payee has misused any individual's benefit paid to such representative payee pursuant to this subsection or section 1007 or 1383(a)(2) of this title, the Commissioner of Social Security shall promptly revoke certification for payment of benefits to such representative payee pursuant to this subsection and certify payment to an alternative representative payee or, if the interest of the individual under this subchapter would be served thereby, to the individual.

(B) In the case of an individual entitled to benefits based on disability, the payment of such benefits shall be made to a representative payee if the Commissioner of Social Security determines that such payment would serve the interest of the individual because the individual also has an alcoholism or drug addiction condition (as determined by the Commissioner) and the individual is incapable of managing such benefits.

(2)

(A) Any certification made under paragraph (1) for payment of benefits to an individual's representative payee shall be made on the basis of—

- (i) an investigation by the Commissioner of Social Security of the person to serve as representative payee, which shall be conducted in advance of such certification and shall, to the extent practicable, include a face-to-face interview with such person, and
- (ii) adequate evidence that such certification is in the interest of such individual (as determined by the Commissioner of Social Security in regulations).

(B)

(i) As part of the investigation referred to in subparagraph (A)(i), the Commissioner of Social Security shall—

- (I) require the person being investigated to submit documented proof of the identity of such person, unless information establishing such identity has been submitted with an application for benefits under this subchapter, subchapter VIII of this chapter, or subchapter XVI of this chapter,
- (II) verify such person's social security account number (or employer identification number),

- (III) determine whether such person has been convicted of a violation of section 408, 1011, or 1383a of this title,
 - (IV) obtain information concerning whether such person has been convicted of any other offense under Federal or State law which resulted in imprisonment for more than 1 year,
 - (V) obtain information concerning whether such person is a person described in section 402(x)(1)(A)(iv) of this title, and
 - (VI) determine whether certification of payment of benefits to such person has been revoked pursuant to this subsection, the designation of such person as a representative payee has been revoked pursuant to section 1007(a) of this title, or payment of benefits to such person has been terminated pursuant to section 1383(a)(2)(A)(iii) of this title by reason of misuse of funds paid as benefits under this subchapter, subchapter VIII of this chapter [42 U.S.C.A. § 1001 et seq.], or subchapter XVI of this chapter.
- (ii) The Commissioner of Social Security shall establish and maintain a centralized file, which shall be updated periodically and which shall be in a form which renders it readily retrievable by each servicing office of the Social Security Administration. Such file shall consist of—
- (I) a list of the names and social security account numbers (or employer identifi-

cation numbers) of all persons with respect to whom certification of payment of benefits has been revoked on or after January 1, 1991, pursuant to this subsection, whose designation as a representative payee has been revoked pursuant to section 1007(a) of this title, or with respect to whom payment of benefits has been terminated on or after such date pursuant to section 1383(a)(2)(A)(iii) of this title, by reason of misuse of funds paid as benefits under this subchapter, subchapter VIII of this chapter, or subchapter XVI of this chapter, and

- (II) a list of the names and social security account numbers (or employer identification numbers) of all persons who have been convicted of a violation of section 408, 1011 of this title, or 1383a of this title.
- (iii) Notwithstanding the provisions of section 552a of Title 5 or any other provision of Federal or State law (other than section 6103 of the Internal Revenue Code of 1986 [Title 26, U.S.C.A.] and section 1306(c) of this title), the Commissioner shall furnish any Federal, State, or local law enforcement officer, upon the written request of the officer, with the current address, social security account number, and photograph (if applicable) of any person investigated under this paragraph, if the officer furnishes the Commissioner with the name of such person and

such other identifying information as may reasonably be required by the Commissioner to establish the unique identity of such person, and notifies the Commissioner that—

- (I) such person is described in section 402(x)(1)(A)(iv) of this title,
- (II) such person has information that is necessary for the officer to conduct the officer's official duties, and
- (III) the location or apprehension of such person is within the officer's official duties.

(C)

- (i) Benefits of an individual may not be certified for payment to any other person pursuant to this subsection if—

- (I) such person has previously been convicted as described in subparagraph (B)(i)(III),
- (II) except as provided in clause (ii), certification of payment of benefits to such person under this subsection has previously been revoked as described in subparagraph (B)(i)(VI) the designation of such person as a representative payee has been revoked pursuant to section 1007(a) of this title, or payment of benefits to such person pursuant to section 1383(a)(2)(A)(ii) of this title has previously been terminated as described in section 1383(a)(2)(B)(ii)(VI) of this title,

- (III) except as provided in clause (iii), such person is a creditor of such individual who provides such individual with goods or services for consideration,
 - (IV) such person has previously been convicted as described in subparagraph (B)(i)(IV), unless the Commissioner determines that such certification would be appropriate notwithstanding such conviction, or
 - (V) such person is a person described in section 402(x)(1)(A)(iv) of this title.
- (ii) The Commissioner of Social Security shall prescribe regulations under which the Commissioner of Social Security may grant exemptions to any person from the provisions of clause (i)(II) on a case-by-case basis if such exemption is in the best interest of the individual whose benefits would be paid to such person pursuant to this subsection.
 - (iii) Clause (i)(III) shall not apply with respect to any person who is a creditor referred to therein if such creditor is—
 - (I) a relative of such individual if such relative resides in the same household as such individual,
 - (II) a legal guardian or legal representative of such individual,
 - (III) a facility that is licensed or certified as a care facility under the law of a State or a political subdivision of a State,

- (IV) a person who is an administrator, owner, or employee of a facility referred to in subclause (III) if such individual resides in such facility, and the certification of payment to such facility or such person is made only after good faith efforts have been made by the local servicing office of the Social Security Administration to locate an alternative representative payee to whom such certification of payment would serve the best interests of such individual, or
 - (V) an individual who is determined by the Commissioner of Social Security, on the basis of written findings and under procedures which the Commissioner of Social Security shall prescribe by regulation, to be acceptable to serve as a representative payee.
- (iv) The procedures referred to in clause (iii)(V) shall require the individual who will serve as representative payee to establish, to the satisfaction of the Commissioner of Social Security, that—
- (I) such individual poses no risk to the beneficiary,
 - (II) the financial relationship of such individual to the beneficiary poses no substantial conflict of interest, and
 - (III) no other more suitable representative payee can be found.

- (v) In the case of an individual described in paragraph (1)(B), when selecting such individual's representative payee, preference shall be given to—
 - (I) a certified community-based nonprofit social service agency (as defined in paragraph (10)),
 - (II) a Federal, State, or local government agency whose mission is to carry out income maintenance, social service, or health care-related activities,
 - (III) a State or local government agency with fiduciary responsibilities, or
 - (IV) a designee of an agency (other than of a Federal agency) referred to in the preceding subclauses of this clause, if the Commissioner of Social Security deems it appropriate,

unless the Commissioner of Social Security determines that selection of a family member would be appropriate.
- (D)
 - (i) Subject to clause (ii), if the Commissioner of Social Security makes a determination described in the first sentence of paragraph (1) with respect to any individual's benefit and determines that direct payment of the benefit to the individual would cause substantial harm to the individual, the Commissioner of Social Security may defer (in the case of initial entitlement) or suspend (in the case of existing entitlement) direct

payment of such benefit to the individual, until such time as the selection of a representative payee is made pursuant to this subsection.

(ii)

(I) Except as provided in subclause (II), any deferral or suspension of direct payment of a benefit pursuant to clause (i) shall be for a period of not more than 1 month.

(II) Subclause (I) shall not apply in any case in which the individual is, as of the date of the Commissioner's determination, legally incompetent, under the age of 15 years, or described in paragraph (1)(B).

(iii) Payment pursuant to this subsection of any benefits which are deferred or suspended pending the selection of a representative payee shall be made to the individual or the representative payee as a single sum or over such period of time as the Commissioner of Social Security determines is in the best interest of the individual entitled to such benefits.

(E)

(i) Any individual who is dissatisfied with a determination by the Commissioner of Social Security to certify payment of such individual's benefit to a representative payee under paragraph (1) or with the designation of a particular person to serve as represent-

ative payee shall be entitled to a hearing by the Commissioner of Social Security to the same extent as is provided in subsection (b) of this section, and to judicial review of the Commissioner's final decision as is provided in subsection (g) of this section.

- (ii) In advance of the certification of payment of an individual's benefit to a representative payee under paragraph (1), the Commissioner of Social Security shall provide written notice of the Commissioner's initial determination to certify such payment. Such notice shall be provided to such individual, except that, if such individual—

- (I) is under the age of 15,

- (II) is an unemancipated minor under the age of 18, or

- (III) is legally incompetent,

- then such notice shall be provided solely to the legal guardian or legal representative of such individual.

- (iii) Any notice described in clause (ii) shall be clearly written in language that is easily understandable to the reader, shall identify the person to be designated as such individual's representative payee, and shall explain to the reader the right under clause (i) of such individual or of such individual's legal guardian or legal representative—

- (I) to appeal a determination that a representative payee is necessary for such individual,

- (II) to appeal the designation of a particular person to serve as the representative payee of such individual, and
- (III) to review the evidence upon which such designation is based and submit additional evidence.

(3)

(A) In any case where payment under this subchapter is made to a person other than the individual entitled to such payment, the Commissioner of Social Security shall establish a system of accountability monitoring whereby such person shall report not less often than annually with respect to the use of such payments. The Commissioner of Social Security shall establish and implement statistically valid procedures for reviewing such reports in order to identify instances in which such persons are not properly using such payments.

(B) Subparagraph (A) shall not apply in any case where the other person to whom such payment is made is a State institution. In such cases, the Commissioner of Social Security shall establish a system of accountability monitoring for institutions in each State.

(C) Subparagraph (A) shall not apply in any case where the individual entitled to such payment is a resident of a Federal institution and the other person to whom such payment is made is the institution.

(D) Notwithstanding subparagraphs (A), (B), and (C), the Commissioner of Social Security

may require a report at any time from any person receiving payments on behalf of another, if the Commissioner of Social Security has reason to believe that the person receiving such payments is misusing such payments.

(E) In any case in which the person described in subparagraph (A) or (D) receiving payments on behalf of another fails to submit a report required by the Commissioner of Social Security under subparagraph (A) or (D), the Commissioner may, after furnishing notice to such person and the individual entitled to such payment, require that such person appear in person at a field office of the Social Security Administration serving the area in which the individual resides in order to receive such payments.

(F) The Commissioner of Social Security shall maintain a centralized file, which shall be updated periodically and which shall be in a form which will be readily retrievable by each servicing office of the Social Security Administration, of—

- (i) the address and the social security account number (or employer identification number) of each representative payee who is receiving benefit payments pursuant to this subsection, section 1007 of this title, or section 1383(a)(2) of this title, and
- (ii) the address and social security account number of each individual for whom each representative payee is reported to be providing services as representative payee pur-

suant to this subsection, section 1007 of this title, or section 1383(a)(2) of this title.

(G) Each servicing office of the Administration shall maintain a list, which shall be updated periodically, of public agencies and certified community-based nonprofit social service agencies (as defined in paragraph (10)) which are qualified to serve as representative payees pursuant to this subsection or section 1007 or 1383(a)(2) of this title and which are located in the area served by such servicing office.

(4)

(A)

(i) Except as provided in the next sentence, a qualified organization may collect from an individual a monthly fee for expenses (including overhead) incurred by such organization in providing services performed as such individual's representative payee pursuant to this subsection if such fee does not exceed the lesser of—

(I) 10 percent of the monthly benefit involved, or

(II) \$25.00 per month (\$50.00 per month in any case in which the individual is described in paragraph (1)(B)).

A qualified organization may not collect a fee from an individual for any month with respect to which the Commissioner of Social Security or a court of competent jurisdiction has determined that the organization misused all or

part of the individual's benefit, and any amount so collected by the qualified organization for such month shall be treated as a misused part of the individual's benefit for purposes of paragraphs (5) and (6). The Commissioner shall adjust annually (after 1995) each dollar amount set forth in subclause (II) under procedures providing for adjustments in the same manner and to the same extent as adjustments are provided for under the procedures used to adjust benefit amounts under section 415(i)(2)(A) of this title, except that any amount so adjusted that is not a multiple of \$1.00 shall be rounded to the nearest multiple of \$1.00. Any agreement providing for a fee in excess of the amount permitted under this subparagraph shall be void and shall be treated as misuse by such organization of such individual's benefits.

- (ii) In the case of an individual who is no longer currently entitled to monthly insurance benefits under this subchapter but to whom all past-due benefits have not been paid, for purposes of clause (i), any amount of such past-due benefits payable in any month shall be treated as a monthly benefit referred to in clause (i)(I).

(B) For purposes of this paragraph, the term "qualified organization" means any State or local government agency whose mission is to carry out income maintenance, social service, or health

care-related activities, any State or local government agency with fiduciary responsibilities, or any certified community-based nonprofit social service agency (as defined in paragraph (10)), if such agency, in accordance with any applicable regulations of the Commissioner of Social Security—

- (i) regularly provides services as the representative payee, pursuant to this subsection or section 1007 or 1383(a)(2) of this title, concurrently to 5 or more individuals,³
- (ii) demonstrates to the satisfaction of the Commissioner of Social Security that such agency is not otherwise a creditor of any such individual.

The Commissioner of Social Security shall prescribe regulations under which the Commissioner of Social Security may grant an exception from clause (ii) for any individual on a case-by-case basis if such exception is in the best interests of such individual.

(C) Any qualified organization which knowingly charges or collects, directly or indirectly, any fee in excess of the maximum fee prescribed under subparagraph (A) or makes any agreement, directly or indirectly, to charge or collect any fee in excess of such maximum fee, shall be fined in accordance with Title 18, or imprisoned not more than 6 months, or both.

- (5) In cases where the negligent failure of the Commissioner of Social Security to investigate or monitor a representative payee results in misuse of benefits by the representative payee, the Commissioner of

Social Security shall certify for payment to the beneficiary or the beneficiary's alternative representative payee an amount equal to such misused benefits. In any case in which a representative payee that—

(A) is not an individual (regardless of whether it is a “qualified organization” within the meaning of paragraph (4)(B)); or

(B) is an individual who, for any month during a period when misuse occurs, serves 15 or more individuals who are beneficiaries under this subchapter, subchapter VIII of this chapter, subchapter XVI of this chapter, or any combination of such subchapters;

misuses all or part of an individual's benefit paid to such representative payee, the Commissioner of Social Security shall certify for payment to the beneficiary or the beneficiary's alternative representative payee an amount equal to the amount of such benefit so misused. The provisions of this paragraph are subject to the limitations of paragraph (7)(B). The Commissioner of Social Security shall make a good faith effort to obtain restitution from the terminated representative payee.

(6)

(A) In addition to such other reviews of representative payees as the Commissioner of Social Security may otherwise conduct, the Commissioner shall provide for the periodic onsite review of any person or agency located in the United States that receives the benefits payable under this subchapter (alone or in combination

with benefits payable under subchapter VIII of this chapter or subchapter XVI of this chapter) to another individual pursuant to the appointment of such person or agency as a representative payee under this subsection, section 1007 of this title, or section 1383(a)(2) of this title in any case in which—

- (i) the representative payee is a person who serves in that capacity with respect to 15 or more such individuals;
- (ii) the representative payee is a certified community-based nonprofit social service agency (as defined in paragraph (10) of this subsection or section 1383(a)(2)(I) of this title); or
- (iii) the representative payee is an agency (other than an agency described in clause (ii)) that serves in that capacity with respect to 50 or more such individuals.

(B) Within 120 days after the end of each fiscal year, the Commissioner shall submit to the Committee on Ways and Means of the House of Representatives and the Committee on Finance of the Senate a report on the results of periodic onsite reviews conducted during the fiscal year pursuant to subparagraph (A) and of any other reviews of representative payees conducted during such fiscal year in connection with benefits under this subchapter. Each such report shall describe in detail all problems identified in such reviews and any corrective action taken or planned to be taken to correct such problems, and shall include—

- (i) the number of such reviews;
 - (ii) the results of such reviews;
 - (iii) the number of cases in which the representative payee was changed and why;
 - (iv) the number of cases involving the exercise of expedited, targeted oversight of the representative payee by the Commissioner conducted upon receipt of an allegation of misuse of funds, failure to pay a vendor, or a similar irregularity;
 - (v) the number of cases discovered in which there was a misuse of funds;
 - (vi) how any such cases of misuse of funds were dealt with by the Commissioner;
 - (vii) the final disposition of such cases of misuse of funds, including any criminal penalties imposed; and
 - (viii) such other information as the Commissioner deems appropriate.
- (7)
- (A) If the Commissioner of Social Security or a court of competent jurisdiction determines that a representative payee that is not a Federal, State, or local government agency has misused all or part of an individual's benefit that was paid to such representative payee under this subsection, the representative payee shall be liable for the amount misused, and such amount (to the extent not repaid by the representative payee) shall be treated as an overpayment of benefits under this subchapter to the represent-

ative payee for all purposes of this chapter and related laws pertaining to the recovery of such overpayments. Subject to subparagraph (B), upon recovering all or any part of such amount, the Commissioner shall certify an amount equal to the recovered amount for payment to such individual or such individual's alternative representative payee.

(B) The total of the amount certified for payment to such individual or such individual's alternative representative payee under subparagraph (A) and the amount certified for payment under paragraph (5) may not exceed the total benefit amount misused by the representative payee with respect to such individual.

(8) For purposes of this subsection, the term "benefit based on disability" of an individual means a disability insurance benefit of such individual under section 423 of this title or a child's, widow's, or widower's insurance benefit of such individual under section 402 of this title based on such individual's disability.

(9) For purposes of this subsection, misuse of benefits by a representative payee occurs in any case in which the representative payee receives payment under this subchapter for the use and benefit of another person and converts such payment, or any part thereof, to a use other than for the use and benefit of such other person. The Commissioner of Social Security may prescribe by regulation the meaning of the term "use and benefit" for purposes of this paragraph.

(10) For purposes of this subsection, the term “certified community-based nonprofit social service agency” means a community-based nonprofit social service agency which is in compliance with requirements, under regulations which shall be prescribed by the Commissioner, for annual certification to the Commissioner that it is bonded in accordance with requirements specified by the Commissioner and that it is licensed in each State in which it serves as a representative payee (if licensing is available in the State) in accordance with requirements specified by the Commissioner. Any such annual certification shall include a copy of any independent audit on the agency which may have been performed since the previous certification.

(k) Payments to Incompetents

Any payment made after December 31, 1939, under conditions set forth in subsection (j) of this section, any payment made before January 1, 1940, to, or on behalf of, a legally incompetent individual, and any payment made after December 31, 1939, to a legally incompetent individual without knowledge by the Commissioner of Social Security of incompetency prior to certification of payment, if otherwise valid under this subchapter, shall be a complete settlement and satisfaction of any claim, right, or interest in and to such payment.

(l) Delegation of Powers and Duties by Commissioner

The Commissioner of Social Security is authorized to delegate to any member, officer, or employee of the Social Security Administration designated by the Commissioner any of the powers conferred upon the

Commissioner by this section, and is authorized to be represented by the Commissioner's own attorneys in any court in any case or proceeding arising under the provisions of subsection (e) of this section.

(m) Repealed. Aug. 28, 1950, c. 809, Title I, § 101(b)(2), 64 Stat. 488

(n) Joint Payments

The Commissioner of Social Security may, in the Commissioner's discretion, certify to the Managing Trustee any two or more individuals of the same family for joint payment of the total benefits payable to such individuals for any month, and if one of such individuals dies before a check representing such joint payment is negotiated, payment of the amount of such unnegotiated check to the surviving individual or individuals may be authorized in accordance with regulations of the Secretary of the Treasury; except that appropriate adjustment or recovery shall be made under section 404(a) of this title with respect to so much of the amount of such check as exceeds the amount to which such surviving individual or individuals are entitled under this subchapter for such month.

(o) Crediting of Compensation Under Railroad Retirement Act

If there is no person who would be entitled, upon application therefor, to an annuity under section 2 of the Railroad Retirement Act of 1974 [45 U.S.C.A. § 231a], or to a lump-sum payment under section 6(b) of such Act [45 U.S.C.A. § 231e(b)], with respect to the death of an employee (as defined in such Act),

then, notwithstanding section 410(a)(9) of this title, compensation (as defined in such Railroad Retirement Act, but excluding compensation attributable as having been paid during any month on account of military service creditable under section 3(i) of such Act [45 U.S.C.A. § 231b(i)] if wages are deemed to have been paid to such employee during such month under subsection (a) or (e) of section 417 of this title) of such employee shall constitute remuneration for employment for purposes of determining (A) entitlement to and the amount of any lump-sum death payment under this subchapter on the basis of such employee's wages and self-employment income and (B) entitlement to and the amount of any monthly benefit under this subchapter, for the month in which such employee died or for any month thereafter, on the basis of such wages and self-employment income. For such purposes, compensation (as so defined) paid in a calendar year before 1978 shall, in the absence of evidence to the contrary, be presumed to have been paid in equal proportions with respect to all months in the year in which the employee rendered services for such compensation.

(p) Special Rules in Case of Federal Service

(1) With respect to service included as employment under section 410 of this title which is performed in the employ of the United States or in the employ of any instrumentality which is wholly owned by the United States, including service, performed as a member of a uniformed service, to which the provisions of subsection (l)(1) of such section are applicable, and including service, performed as a volunteer or volunteer leader within the meaning of the Peace Corps Act [22 U.S.C.A. § 2501 et seq.], to which the

provisions of section 410(o) of this title are applicable, the Commissioner of Social Security shall not make determinations as to the amounts of remuneration for such service, or the periods in which or for which such remuneration was paid, but shall accept the determinations with respect thereto of the head of the appropriate Federal agency or instrumentality, and of such agents as such head may designate, as evidenced by returns filed in accordance with the provisions of section 3122 of the Internal Revenue Code of 1954, and certifications made pursuant to this subsection. Such determinations shall be final and conclusive. Nothing in this paragraph shall be construed to affect the Commissioner's authority to determine under sections 409 and 410 of this title whether any such service constitutes employment, the periods of such employment, and whether remuneration paid for any such service constitutes wages.

(2) The head of any such agency or instrumentality is authorized and directed, upon written request of the Commissioner of Social Security, to make certification to the Commissioner with respect to any matter determinable for the Commissioner of Social Security by such head or his agents under this subsection, which the Commissioner of Social Security finds necessary in administering this subchapter.

(3) The provisions of paragraphs (1) and (2) of this subsection shall be applicable in the case of service performed by a civilian employee, not compensated from funds appropriated by the Congress, in the Army and Air Force Exchange Service, Army and Air Force Motion Picture Service, Navy Exchanges, Marine

Corps Exchanges, or other activities, conducted by an instrumentality of the United States subject to the jurisdiction of the Secretary of Defense, at installations of the Department of Defense for the comfort, pleasure, contentment, and mental and physical improvement of personnel of such Department; and for purposes of paragraphs (1) and (2) of this subsection the Secretary of Defense shall be deemed to be the head of such instrumentality. The provisions of paragraphs (1) and (2) shall be applicable also in the case of service performed by a civilian employee, not compensated from funds appropriated by the Congress, in the Coast Guard Exchanges or other activities, conducted by an instrumentality of the United States subject to the jurisdiction of the Secretary of Homeland Security, at installations of the Coast Guard for the comfort, pleasure, contentment, and mental and physical improvement of personnel of the Coast Guard; and for purposes of paragraphs (1) and (2) the Secretary of Homeland Security shall be deemed to be the head of such instrumentality.

(q) Expedited Benefit Payments

(1) The Commissioner of Social Security shall establish and put into effect procedures under which expedited payment of monthly insurance benefits under this subchapter will, subject to paragraph (4) of this subsection, be made as set forth in paragraphs (2) and (3) of this subsection.

(2) In any case in which—

(A) an individual makes an allegation that a monthly benefit under this subchapter was due

him in a particular month but was not paid to him, and

(B) such individual submits a written request for the payment of such benefit—

- (i) in the case of an individual who received a regular monthly benefit in the month preceding the month with respect to which such allegation is made, not less than 30 days after the 15th day of the month with respect to which such allegation is made (and in the event that such request is submitted prior to the expiration of such 30-day period, it shall be deemed to have been submitted upon the expiration of such period), and
- (ii) in any other case, not less than 90 days after the later of (I) the date on which such benefit is alleged to have been due, or (II) the date on which such individual furnished the last information requested by the Commissioner of Social Security (and such written request will be deemed to be filed on the day on which it was filed, or the ninetieth day after the first day on which the Commissioner of Social Security has evidence that such allegation is true, whichever is later),

the Commissioner of Social Security shall, if the Commissioner finds that benefits are due, certify such benefits for payment, and payment shall be made within 15 days immediately

following the date on which the written request is deemed to have been filed.

(3) In any case in which the Commissioner of Social Security determines that there is evidence, although additional evidence might be required for a final decision, that an allegation described in paragraph (2)(A) is true, the Commissioner may make a preliminary certification of such benefit for payment even though the 30-day or 90-day periods described in paragraph (2)(B)(i) and (B)(ii) have not elapsed.

(4) Any payment made pursuant to a certification under paragraph (3) of this subsection shall not be considered an incorrect payment for purposes of determining the liability of the certifying or disbursing officer.

(5) For purposes of this subsection, benefits payable under section 428 of this title shall be treated as monthly insurance benefits payable under this subchapter. However, this subsection shall not apply with respect to any benefit for which a check has been negotiated, or with respect to any benefit alleged to be due under either section 423 of this title, or section 402 of this title to a wife, husband, or child of an individual entitled to or applying for benefits under section 423 of this title, or to a child who has attained age 18 and is under a disability, or to a widow or widower on the basis of being under a disability.

(r) Use of Death Certificates to Correct Program Information

(1) The Commissioner of Social Security shall undertake to establish a program under which—

(A) States (or political subdivisions thereof) voluntarily contract with the Commissioner of Social Security to furnish the Commissioner of Social Security periodically with information (in a form established by the Commissioner of Social Security in consultation with the States) concerning individuals with respect to whom death certificates (or equivalent documents maintained by the States or subdivisions) have been officially filed with them; and

(B) there will be (i) a comparison of such information on such individuals with information on such individuals in the records being used in the administration of this chapter, (ii) validation of the results of such comparisons, and (iii) corrections in such records to accurately reflect the status of such individuals.

(2) Each State (or political subdivision thereof) which furnishes the Commissioner of Social Security with information on records of deaths in the State or subdivision under this subsection may be paid by the Commissioner of Social Security from amounts available for administration of this chapter the reasonable costs (established by the Commissioner of Social Security in consultations with the States) for transcribing and transmitting such information to the Commissioner of Social Security.

(3) In the case of individuals with respect to whom federally funded benefits are provided by (or through) a Federal or State agency other than under this chapter, the Commissioner of Social Security shall to the extent feasible provide such information through a cooperative arrangement with such agency, for

ensuring proper payment of those benefits with respect to such individuals if—

(A) under such arrangement the agency provides reimbursement to the Commissioner of Social Security for the reasonable cost of carrying out such arrangement, and

(B) such arrangement does not conflict with the duties of the Commissioner of Social Security under paragraph (1).

(4) The Commissioner of Social Security may enter into similar agreements with States to provide information for their use in programs wholly funded by the States if the requirements of subparagraphs (A) and (B) of paragraph (3) are met.

(5) The Commissioner of Social Security may use or provide for the use of such records as may be corrected under this section, subject to such safeguards as the Commissioner of Social Security determines are necessary or appropriate to protect the information from unauthorized use or disclosure, for statistical and research activities conducted by Federal and State agencies.

(6) Information furnished to the Commissioner of Social Security under this subsection may not be used for any purpose other than the purpose described in this subsection and is exempt from disclosure under section 552 of Title 5, and from the requirements of section 552a of such title.

(7) The Commissioner of Social Security shall include information on the status of the program established under this section and impediments to the effective

implementation of the program in the 1984 report required under section 904 of this title.

(8)

(A) The Commissioner of Social Security shall, upon the request of the official responsible for a State driver's license agency pursuant to the Help America Vote Act of 2002—

(i) enter into an agreement with such official for the purpose of verifying applicable information, so long as the requirements of subparagraphs (A) and (B) of paragraph (3) are met; and

(ii) include in such agreement safeguards to assure the maintenance of the confidentiality of any applicable information disclosed and procedures to permit such agency to use the applicable information for the purpose of maintaining its records.

(B) Information provided pursuant to an agreement under this paragraph shall be provided at such time, in such place, and in such manner as the Commissioner determines appropriate.

(C) The Commissioner shall develop methods to verify the accuracy of information provided by the agency with respect to applications for voter registration, for whom the last 4 digits of a social security number are provided instead of a driver's license number.

(D) For purposes of this paragraph—

(i) the term “applicable information” means information regarding whether—

- (I) the name (including the first name and any family forename or surname), the date of birth (including the month, day, and year), and social security number of an individual provided to the Commissioner match the information contained in the Commissioner's records, and
 - (II) such individual is shown on the records of the Commissioner as being deceased; and
 - (ii) the term "State driver's license agency" means the State agency which issues driver's licenses to individuals within the State and maintains records relating to such licensure.
- (E) Nothing in this paragraph may be construed to require the provision of applicable information with regard to a request for a record of an individual if the Commissioner determines there are exceptional circumstances warranting an exception (such as safety of the individual or interference with an investigation).
- (F) Applicable information provided by the Commission pursuant to an agreement under this paragraph or by an individual to any agency that has entered into an agreement under this paragraph shall be considered as strictly confidential and shall be used only for the purposes described in this paragraph and for carrying out an agreement under this paragraph. Any officer or employee or former officer or employee of a State, or any officer or employee or former officer or employee of a contractor of a State who,

without the written authority of the Commissioner, publishes or communicates any applicable information in such individual's possession by reason of such employment or position as such an officer, shall be guilty of a felony and upon conviction thereof shall be fined or imprisoned, or both, as described in section 408 of this title.

(9)

(A) The Commissioner of Social Security shall, upon the request of the Secretary or the Inspector General of the Department of Health and Human Services—

- (i) enter into an agreement with the Secretary or such Inspector General for the purpose of matching data in the system of records of the Social Security Administration and the system of records of the Department of Health and Human Services; and
- (ii) include in such agreement safeguards to assure the maintenance of the confidentiality of any information disclosed.

(B) For purposes of this paragraph, the term “system of records” has the meaning given such term in section 552a(a)(5) of Title 5.

(s) Notice Requirements

The Commissioner of Social Security shall take such actions as are necessary to ensure that any notice to one or more individuals issued pursuant to this subchapter by the Commissioner of Social Security or by a State agency—

- (1) is written in simple and clear language, and
- (2) includes the address and telephone number of the local office of the Social Security Administration which serves the recipient.

In the case of any such notice which is not generated by a local servicing office, the requirements of paragraph (2) shall be treated as satisfied if such notice includes the address of the local office of the Social Security Administration which services the recipient of the notice and a telephone number through which such office can be reached.

(t) Same-Day Personal Interviews at Field Offices in Cases Where Time is of Essence

In any case in which an individual visits a field office of the Social Security Administration and represents during the visit to an officer or employee of the Social Security Administration in the office that the individual's visit is occasioned by—

- (1) the receipt of a notice from the Social Security Administration indicating a time limit for response by the individual, or
- (2) the theft, loss, or nonreceipt of a benefit payment under this subchapter,

the Commissioner of Social Security shall ensure that the individual is granted a face-to-face interview at the office with an officer or employee of the Social Security Administration before the close of business on the day of the visit.

(u) Redetermination of Entitlement

(1)

(A) The Commissioner of Social Security shall immediately redetermine the entitlement of individuals to monthly insurance benefits under this subchapter if there is reason to believe that fraud or similar fault was involved in the application of the individual for such benefits, unless a United States attorney, or equivalent State prosecutor, with jurisdiction over potential or actual related criminal cases, certifies, in writing, that there is a substantial risk that such action by the Commissioner of Social Security with regard to beneficiaries in a particular investigation would jeopardize the criminal prosecution of a person involved in a suspected fraud.

(B) When redetermining the entitlement, or making an initial determination of entitlement, of an individual under this subchapter, the Commissioner of Social Security shall disregard any evidence if there is reason to believe that fraud or similar fault was involved in the providing of such evidence.

(2) For purposes of paragraph (1), similar fault is involved with respect to a determination if—

(A) an incorrect or incomplete statement that is material to the determination is knowingly made; or

(B) information that is material to the determination is knowingly concealed.

(3) If, after redetermining pursuant to this subsection the entitlement of an individual to monthly insurance benefits, the Commissioner of Social Security determines that there is insufficient evidence to support such entitlement, the Commissioner of Social Security may terminate such entitlement and may treat benefits paid on the basis of such insufficient evidence as overpayments.

42 U.S.C. § 1395cc—Agreements with providers of services; enrollment processes

(a) Filing of Agreements; Eligibility for Payment; Charges with Respect to Items and Services

(1) Any provider of services (except a fund designated for purposes of section 1395f(g) and section 1395n(e) of this title) shall be qualified to participate under this subchapter and shall be eligible for payments under this subchapter if it files with the Secretary an agreement—

(A)

(i) not to charge, except as provided in paragraph (2), any individual or any other person for items or services for which such individual is entitled to have payment made under this subchapter (or for which he would be so entitled if such provider of services had complied with the procedural and other requirements under or pursuant to this subchapter or for which such provider is paid pursuant to the provisions of section 1395f(e) of this title), and (ii) not to impose any charge that is prohibited under section 1396a(n)(3) of this title,

(B) not to charge any individual or any other person for items or services for which such individual is not entitled to have payment made under this subchapter because payment for expenses incurred for such items or services may not be made by reason of the provisions of paragraph (1) or (9) of section 1395y(a) of this title, but only if (i) such individual was without fault in incurring such expenses and (ii) the Secretary's determination that such payment may not be made for such items and services was made after the third year following the year in which notice of such payment was sent to such individual; except that the Secretary may reduce such three-year period to not less than one year if he finds such reduction is consistent with the objectives of this subchapter,

(C) to make adequate provision for return (or other disposition, in accordance with regulations) of any moneys incorrectly collected from such individual or other person,

(D) to promptly notify the Secretary of its employment of an individual who, at any time during the year preceding such employment, was employed in a managerial, accounting, auditing, or similar capacity (as determined by the Secretary by regulation) by an agency or organization which serves as a fiscal intermediary or carrier (for purposes of part A or part B, or both, of this subchapter) with respect to the provider,

(E) to release data with respect to patients of such provider upon request to an organization having a contract with the Secretary under part

B of subchapter XI of this chapter as may be necessary (i) to allow such organization to carry out its functions under such contract, or (ii) to allow such organization to carry out similar review functions under any contract the organization may have with a private or public agency paying for health care in the same area with respect to patients who authorize release of such data for such purposes,

(F)

- (i) in the case of hospitals which provide inpatient hospital services for which payment may be made under subsection (b), (c), or (d) of section 1395ww of this title, to maintain an agreement with a professional standards review organization (if there is such an organization in existence in the area in which the hospital is located) or with a quality improvement organization which has a contract with the Secretary under part B of subchapter XI of this chapter for the area in which the hospital is located, under which the organization will perform functions under that part with respect to the review of the validity of diagnostic information provided by such hospital, the completeness, adequacy, and quality of care provided, the appropriateness of admissions and discharges, and the appropriateness of care provided for which additional payments are sought under section 1395ww(d)(5) of this title, with respect to inpatient hospital services for which payment may be made under part A of this subchapter (and for

purposes of payment under this subchapter, the cost of such agreement to the hospital shall be considered a cost incurred by such hospital in providing inpatient services under part A of this subchapter, and (I) shall be paid directly by the Secretary to such organization on behalf of such hospital in accordance with a rate per review established by the Secretary, (II) shall be transferred from the Federal Hospital Insurance Trust Fund, without regard to amounts appropriated in advance in appropriation Acts, in the same manner as transfers are made for payment for services provided directly to beneficiaries, and (III) shall not be less in the aggregate for a fiscal year than the aggregate amount expended in fiscal year 1988 for direct and administrative costs (adjusted for inflation and for any direct or administrative costs incurred as a result of review functions added with respect to a subsequent fiscal year) of such reviews),

- (ii) in the case of hospitals, critical access hospitals, skilled nursing facilities, and home health agencies, to maintain an agreement with a quality improvement organization (which has a contract with the Secretary under part B of subchapter XI of this chapter for the area in which the hospital, facility, or agency is located) to perform the functions described in paragraph (3)(A),

(G) in the case of hospitals which provide inpatient hospital services for which payment may be made under subsection (b) or (d) of section 1395ww of this title, not to charge any individual or any other person for inpatient hospital services for which such individual would be entitled to have payment made under part A of this subchapter but for a denial or reduction of payments under section 1395ww(f)(2) of this title,

(H)

(i) in the case of hospitals which provide services for which payment may be made under this subchapter and in the case of critical access hospitals which provide critical access hospital services, to have all items and services (other than physicians' services as defined in regulations for purposes of section 1395y(a)(14) of this title, and other than services described by section 1395x(s)(2)(K) of this title, certified nurse-, and services of a certified registered nurse anesthetist) (I) that are furnished to an individual who is a patient of the hospital, and (II) for which the individual is entitled to have payment made under this subchapter, furnished by the hospital or otherwise under arrangements (as defined in section 1395x(w)(1) of this title) made by the hospital,

(ii) in the case of skilled nursing facilities which provide covered skilled nursing facility services—

- (I) that are furnished to an individual who is a resident of the skilled nursing facility during a period in which the resident is provided covered post-hospital extended care services (or, for services described in section 1395x(s)(2)(D) of this title, that are furnished to such an individual without regard to such period), and
- (II) for which the individual is entitled to have payment made under this subchapter,
 - to have items and services (other than services described in section 1395yy(e)(2)(A)(ii) of this title) furnished by the skilled nursing facility or otherwise under arrangements (as defined in section 1395x(w)(1) of this title) made by the skilled nursing facility,
- (I) in the case of a hospital or critical access hospital—
 - (i) to adopt and enforce a policy to ensure compliance with the requirements of section 1395dd of this title and to meet the requirements of such section,
 - (ii) to maintain medical and other records related to individuals transferred to or from the hospital for a period of five years from the date of the transfer, and
 - (iii) to maintain a list of physicians who are on call for duty after the initial examination to provide treatment necessary to stabilize an

individual with an emergency medical condition,

(J) in the case of hospitals which provide inpatient hospital services for which payment may be made under this subchapter, to be a participating provider of medical care under any health plan contracted for under section 1079 or 1086 of Title 10, or under section 1713 of Title 38, in accordance with admission practices, payment methodology, and amounts as prescribed under joint regulations issued by the Secretary and by the Secretaries of Defense and Transportation, in implementation of sections 1079 and 1086 of Title 10,

(K) not to charge any individual or any other person for items or services for which payment under this subchapter is denied under section 1320c-3(a)(2) of this title by reason of a determination under section 1320c-3(a)(1)(B) of this title,

(L) in the case of hospitals which provide inpatient hospital services for which payment may be made under this subchapter, to be a participating provider of medical care under section 1703 of Title 38, in accordance with such admission practices, and such payment methodology and amounts, as are prescribed under joint regulations issued by the Secretary and by the Secretary of Veterans Affairs in implementation of such section,

(M) in the case of hospitals, to provide to each individual who is entitled to benefits under part A of this subchapter (or to a person acting on the

individual's behalf), at or about the time of the individual's admission as an inpatient to the hospital, a written statement (containing such language as the Secretary prescribes consistent with this paragraph) which explains—

- (i) the individual's rights to benefits for inpatient hospital services and for post-hospital services under this subchapter,
- (ii) the circumstances under which such an individual will and will not be liable for charges for continued stay in the hospital,
- (iii) the individual's right to appeal denials of benefits for continued inpatient hospital services, including the practical steps to initiate such an appeal, and
- (iv) the individual's liability for payment for services if such a denial of benefits is upheld on appeal,

and which provides such additional information as the Secretary may specify,

(N) in the case of hospitals and critical access hospitals—

- (i) to make available to its patients the directory or directories of participating physicians (published under section 1395u(h)(4) of this title) for the area served by the hospital or critical access hospital,
- (ii) if hospital personnel (including staff of any emergency or outpatient department) refer a patient to a nonparticipating physician for further medical care on an outpatient basis,

the personnel must inform the patient that the physician is a nonparticipating physician and, whenever practicable, must identify at least one qualified participating physician who is listed in such a directory and from whom the patient may receive the necessary services,

- (iii) to post conspicuously in any emergency department a sign (in a form specified by the Secretary) specifying rights of individuals under section 1395dd of this title with respect to examination and treatment for emergency medical conditions and women in labor, and
- (iv) to post conspicuously (in a form specified by the Secretary) information indicating whether or not the hospital participates in the medicaid program under a State plan approved under subchapter XIX of this chapter,
- (O) to accept as payment in full for services that are covered under this subchapter and are furnished to any individual enrolled with a Medicare+Choice organization under part C of this subchapter, with a PACE provider under section 1395eee or 1396u-4 of this title, or with an eligible organization with a risk-sharing contract under section 1395mm of this title, under section 1395mm(i)(2)(A) of this title (as in effect before February 1, 1985), under section 1395b-1(a) of this title, or under section 222(a) of the Social Security Amendments of 1972, which does not have a contract (or, in the case of a PACE provider, contract or other agreement) establish-

ing payment amounts for services furnished to members of the organization or PACE program eligible individuals enrolled with the PACE provider, the amounts that would be made as a payment in full under this subchapter (less any payments under sections 1395ww(d)(11) and 1395ww(h)(3)(D) of this title) if the individuals were not so enrolled,

(P) in the case of home health agencies which provide home health services to individuals entitled to benefits under this subchapter who require catheters, catheter supplies, ostomy bags, and supplies related to ostomy care (described in section 1395x(m)(5) of this title), to offer to furnish such supplies to such an individual as part of their furnishing of home health services,

(Q) in the case of hospitals, skilled nursing facilities, home health agencies, and hospice programs, to comply with the requirement of subsection (f) of this section (relating to maintaining written policies and procedures respecting advance directives),

(R) to contract only with a health care clearinghouse (as defined in section 1320d of this title) that meets each standard and implementation specification adopted or established under part C of subchapter XI of this chapter on or after the date on which the health care clearinghouse is required to comply with the standard or specification,

(S) in the case of a hospital that has a financial interest (as specified by the Secretary in regula-

tions) in an entity to which individuals are referred as described in section 1395x(ee)(2)(H)(ii) of this title, or in which such an entity has such a financial interest, or in which another entity has such a financial interest (directly or indirectly) with such hospital and such an entity, to maintain and disclose to the Secretary (in a form and manner specified by the Secretary) information on—

- (i) the nature of such financial interest,
- (ii) the number of individuals who were discharged from the hospital and who were identified as requiring home health services, and
- (iii) the percentage of such individuals who received such services from such provider (or another such provider),

(T) in the case of hospitals and critical access hospitals, to furnish to the Secretary such data as the Secretary determines appropriate pursuant to subparagraph (E) of section 1395ww(d)(12) of this title to carry out such section,

(U) in the case of hospitals which furnish inpatient hospital services for which payment may be made under this subchapter, to be a participating provider of medical care both—

- (i) under the contract health services program funded by the Indian Health Service and operated by the Indian Health Service, an Indian tribe, or tribal organization (as those terms are defined in section 1603 of Title 25), with respect to items and services that

are covered under such program and furnished to an individual eligible for such items and services under such program; and

- (ii) under any program funded by the Indian Health Service and operated by an urban Indian organization with respect to the purchase of items and services for an eligible urban Indian (as those terms are defined in such section 1603),

in accordance with regulations promulgated by the Secretary regarding admission practices, payment methodology, and rates of payment (including the acceptance of no more than such payment rate as payment in full for such items and services,¹

- (V) in the case of hospitals that are not otherwise subject to the Occupational Safety and Health Act of 1970 [29 U.S.C.A. 651 et seq.] (or a State occupational safety and health plan that is approved under 18(b) of such Act [29 U.S.C.A. 667(b)]), to comply with the Bloodborne Pathogens standard under section 1910.1030 of title 29 of the Code of Federal Regulations (or as subsequently redesignated),

- (W) in the case of a hospital described in section 1395ww(d)(1)(B)(v) of this title, to report quality data to the Secretary in accordance with subsection (k),

- (X) maintain and, upon request of the Secretary, provide access to documentation relating to written orders or requests for payment for durable medical equipment, certifications for home health services, or referrals for other items or services

written or ordered by the provider under this subchapter, as specified by the Secretary, and

(Y) beginning 12 months after August 6, 2015, in the case of a hospital or critical access hospital, with respect to each individual who receives observation services as an outpatient at such hospital or critical access hospital for more than 24 hours, to provide to such individual not later than 36 hours after the time such individual begins receiving such services (or, if sooner, upon release)—

- (i) such oral explanation of the written notification described in clause (ii), and such documentation of the provision of such explanation, as the Secretary determines to be appropriate;
- (ii) a written notification (as specified by the Secretary pursuant to rulemaking and containing such language as the Secretary prescribes consistent with this paragraph) which—
 - (I) explains the status of the individual as an outpatient receiving observation services and not as an inpatient of the hospital or critical access hospital and the reasons for such status of such individual;
 - (II) explains the implications of such status on services furnished by the hospital or critical access hospital (including services furnished on an inpatient basis), such as implications for cost-sharing requirements under this subchapter and for

subsequent eligibility for coverage under this subchapter for services furnished by a skilled nursing facility;

(III) includes such additional information as the Secretary determines appropriate;

(IV) either—

(aa) is signed by such individual or a person acting on such individual's behalf to acknowledge receipt of such notification; or

(bb) if such individual or person refuses to provide the signature described in item (aa), is signed by the staff member of the hospital or critical access hospital who presented the written notification and includes the name and title of such staff member, a certification that the notification was presented, and the date and time the notification was presented; and

(V) is written and formatted using plain language and is made available in appropriate languages as determined by the Secretary.

In the case of a hospital which has an agreement in effect with an organization described in subparagraph (F), which organization's contract with the Secretary under part B of subchapter XI of this chapter is terminated on or after October 1, 1984, the hospital shall not be determined to be out of

compliance with the requirement of such subparagraph during the six month period beginning on the date of the termination of that contract.

(2)

(A) A provider of services may charge such individual or other person (i) the amount of any deduction or coinsurance amount imposed pursuant to section 1395e(a)(1), (a)(3), or (a)(4), section 1395/(b), or section 1395x(y)(3) of this title with respect to such items and services (not in excess of the amount customarily charged for such items and services by such provider), and (ii) an amount equal to 20 per centum of the reasonable charges for such items and services (not in excess of 20 per centum of the amount customarily charged for such items and services by such provider) for which payment is made under part B of this subchapter or which are durable medical equipment furnished as home health services (but in the case of items and services furnished to individuals with end-stage renal disease, an amount equal to 20 percent of the estimated amounts for such items and services calculated on the basis established by the Secretary). In the case of items and services described in section 1395/(c) of this title, clause (ii) of the preceding sentence shall be applied by substituting for 20 percent the proportion which is appropriate under such section. A provider of services may not impose a charge under clause (ii) of the first sentence of this subparagraph with respect to items and services described in section 1395x(s)(10)(A) of this title, and with

respect to clinical diagnostic laboratory tests for which payment is made under part B of this subchapter. Notwithstanding the first sentence of this subparagraph, a home health agency may charge such an individual or person, with respect to covered items subject to payment under section 1395m(a) of this title, the amount of any deduction imposed under section 1395/(b) of this title and 20 percent of the payment basis described in section 1395m(a)(1)(B) of this title. In the case of items and services for which payment is made under part B of this subchapter under the prospective payment system established under section 1395/(t) of this title, clause (ii) of the first sentence shall be applied by substituting for 20 percent of the reasonable charge, the applicable copayment amount established under section 1395/(t)(5) of this title. In the case of services described in section 1395/(a)(8) of this title or section 1395/(a)(9) of this title for which payment is made under part B of this subchapter under section 1395m(k) of this title, clause (ii) of the first sentence shall be applied by substituting for 20 percent of the reasonable charge for such services 20 percent of the lesser of the actual charge or the applicable fee schedule amount (as defined in such section) for such services.

(B) Where a provider of services has furnished, at the request of such individual, items or services which are in excess of or more expensive than the items or services with respect to which payment may be made under this subchapter, such provider of services may also charge such

individual or other person for such more expensive items or services to the extent that the amount customarily charged by it for the items or services furnished at such request exceeds the amount customarily charged by it for the items or services with respect to which payment may be made under this subchapter.

(C) A provider of services may in accordance with its customary practice also appropriately charge any such individual for any whole blood (or equivalent quantities of packed red blood cells, as defined under regulations) furnished him with respect to which a deductible is imposed under section 1395e(a)(2) of this title, except that (i) any excess of such charge over the cost to such provider for the blood (or equivalent quantities of packed red blood cells, as so defined) shall be deducted from any payment to such provider under this subchapter, (ii) no such charge may be imposed for the cost of administration of such blood (or equivalent quantities of packed red blood cells, as so defined), and (iii) such charge may not be made to the extent such blood (or equivalent quantities of packed red blood cells, as so defined) has been replaced on behalf of such individual or arrangements have been made for its replacement on his behalf. For purposes of this subparagraph, whole blood (or equivalent quantities of packed red blood cells, as so defined) furnished an individual shall be deemed replaced when the provider of services is given one pint of blood for each pint of blood (or equivalent quantities of packed red blood cells, as so defined) furnished such individual with

respect to which a deduction is imposed under section 1395e(a)(2) of this title.

(D) Where a provider of services customarily furnishes items or services which are in excess of or more expensive than the items or services with respect to which payment may be made under this subchapter, such provider, notwithstanding the preceding provisions of this paragraph, may not, under the authority of subparagraph (B)(ii) of this paragraph, charge any individual or other person any amount for such items or services in excess of the amount of the payment which may otherwise be made for such items or services under this subchapter if the admitting physician has a direct or indirect financial interest in such provider.

(3)

(A) Under the agreement required under paragraph (1)(F)(ii), the quality improvement organization must perform functions (other than those covered under an agreement under paragraph (1)(F)(i)) under the third sentence of section 1320c-3(a)(4)(A) of this title and under section 1320c-3(a)(14) of this title with respect to services, furnished by the hospital, critical access hospital, facility, or agency involved, for which payment may be made under this subchapter.

(B) For purposes of payment under this subchapter, the cost of such an agreement to the hospital, critical access hospital, facility, or agency shall be considered a cost incurred by such hospital, critical access hospital, facility, or agency in providing covered services under this

subchapter and shall be paid directly by the Secretary to the quality improvement organization on behalf of such hospital, critical access hospital, facility, or agency in accordance with a schedule established by the Secretary.

(C) Such payments—

- (i) shall be transferred in appropriate proportions from the Federal Hospital Insurance Trust Fund and from the Federal Supplementary Medical Insurance Trust Fund, without regard to amounts appropriated in advance in appropriation Acts, in the same manner as transfers are made for payment for services provided directly to beneficiaries, and
- (ii) shall not be less in the aggregate for a fiscal year—
 - (I) in the case of hospitals, than the amount specified in paragraph (1)(F)(i)(III), and
 - (II) in the case of facilities, critical access hospitals, and agencies, than the amounts the Secretary determines to be sufficient to cover the costs of such organizations' conducting the activities described in subparagraph (A) with respect to such facilities, critical access hospitals, or agencies under part B of subchapter XI of this chapter.

(b) Termination or nonrenewal of Agreements

- (1) A provider of services may terminate an agreement with the Secretary under this section at such

time and upon such notice to the Secretary and the public as may be provided in regulations, except that notice of more than six months shall not be required.

(2) The Secretary may refuse to enter into an agreement under this section or, upon such reasonable notice to the provider and the public as may be specified in regulations, may refuse to renew or may terminate such an agreement after the Secretary—

(A) has determined that the provider fails to comply substantially with the provisions of the agreement, with the provisions of this subchapter and regulations thereunder, or with a corrective action required under section 1395ww(f)(2)(B) of this title,

(B) has determined that the provider fails substantially to meet the applicable provisions of section 1395x of this title,

(C) has excluded the provider from participation in a program under this subchapter pursuant to section 1320a-7 of this title or section 1320a-7a of this title, or

(D) has ascertained that the provider has been convicted of a felony under Federal or State law for an offense which the Secretary determines is detrimental to the best interests of the program or program beneficiaries.

(3) A termination of an agreement or a refusal to renew an agreement under this subsection shall become effective on the same date and in the same manner as an exclusion from participation under the programs under this subchapter becomes effective under section 1320a-7(c) of this title.

(4)

(A) A hospital that fails to comply with the requirement of subsection (a)(1)(V) of this section (relating to the Bloodborne Pathogens standard) is subject to a civil money penalty in an amount described in subparagraph (B), but is not subject to termination of an agreement under this section.

(B) The amount referred to in subparagraph (A) is an amount that is similar to the amount of civil penalties that may be imposed under section 17 of the Occupational Safety and Health Act of 1970 [29 U.S.C.A. 666] for a violation of the Bloodborne Pathogens standard referred to in subsection (a)(1)(U) of this section by a hospital that is subject to the provisions of such Act [29 U.S.C.A. 651 et seq.].

(C) A civil money penalty under this paragraph shall be imposed and collected in the same manner as civil money penalties under subsection (a) of section 1320a-7a of this title are imposed and collected under that section.

(c) Refiling After Termination or nonrenewal; Agreements with Skilled Nursing Facilities

(1) Where the Secretary has terminated or has refused to renew an agreement under this subchapter with a provider of services, such provider may not file another agreement under this subchapter unless the Secretary finds that the reason for the termination or nonrenewal has been removed and that there is reasonable assurance that it will not recur.

(2) Where the Secretary has terminated or has refused to renew an agreement under this subchapter with a provider of services, the Secretary shall promptly notify each State agency which administers or supervises the administration of a State plan approved under subchapter XIX of this chapter of such termination or nonrenewal.

(d) Decision to Withhold Payment for Failure to Review Long-Stay Cases

If the Secretary finds that there is a substantial failure to make timely review in accordance with section 1395x(k) of this title of long-stay cases in a hospital, he may, in lieu of terminating his agreement with such hospital, decide that, with respect to any individual admitted to such hospital after a subsequent date specified by him, no payment shall be made under this subchapter for inpatient hospital services (including inpatient psychiatric hospital services) after the 20th day of a continuous period of such services. Such decision may be made effective only after such notice to the hospital and to the public, as may be prescribed by regulations, and its effectiveness shall terminate when the Secretary finds that the reason therefor has been removed and that there is reasonable assurance that it will not recur. The Secretary shall not make any such decision except after reasonable notice and opportunity for hearing to the institution or agency affected thereby.

(e) “Provider of Services” Defined

For purposes of this section, the term “provider of services” shall include—

- (1) a clinic, rehabilitation agency, or public health agency if, in the case of a clinic or rehabilitation agency, such clinic or agency meets the requirements of section 1395x(p)(4)(A) of this title (or meets the requirements of such section through the operation of subsection (g) or (ll)(2) of section 1395x(g) of this title), or if, in the case of a public health agency, such agency meets the requirements of section 1395x(p)(4)(B) of this title (or meets the requirements of such section through the operation of subsection (g) or (ll)(2) of section 1395x(g) of this title), but only with respect to the furnishing of outpatient physical therapy services (as therein defined), (through the operation of section 1395x(g) of this title) with respect to the furnishing of outpatient occupational therapy services, or (through the operation of section 1395x(ll)(2) of this title) with respect to the furnishing of outpatient speech-language pathology; and
- (2) a community mental health center (as defined in section 1395x(ff)(3)(B) of this title), but only with respect to the furnishing of partial hospitalization services (as described in section 1395x(ff)(1) of this title).

(f) Maintenance of Written Policies and Procedures

- (1) For purposes of subsection (a)(1)(Q) of this section and sections 1395i-3(c)(2)(E), 1395/(s), 1395w-25(i), 1395mm(c)(8), and 1395bbb(a)(6) of this title, the requirement of this subsection is that a provider of services, Medicare+Choice organization, or prepaid or eligible organization (as the case may be) maintain written policies and procedures with respect to all adult individuals receiving medical care by or through the provider or organization—

- (A) to provide written information to each such individual concerning—
 - (i) an individual's rights under State law (whether statutory or as recognized by the courts of the State) to make decisions concerning such medical care, including the right to accept or refuse medical or surgical treatment and the right to formulate advance directives (as defined in paragraph (3)), and
 - (ii) the written policies of the provider or organization respecting the implementation of such rights;
- (B) to document in a prominent part of the individual's current medical record whether or not the individual has executed an advance directive;
- (C) not to condition the provision of care or otherwise discriminate against an individual based on whether or not the individual has executed an advance directive;
- (D) to ensure compliance with requirements of State law (whether statutory or as recognized by the courts of the State) respecting advance directives at facilities of the provider or organization; and
- (E) to provide (individually or with others) for education for staff and the community on issues concerning advance directives.

Subparagraph (C) shall not be construed as requiring the provision of care which conflicts with an advance directive.

(2) The written information described in paragraph (1)(A) shall be provided to an adult individual—

(A) in the case of a hospital, at the time of the individual's admission as an inpatient,

(B) in the case of a skilled nursing facility, at the time of the individual's admission as a resident,

(C) in the case of a home health agency, in advance of the individual coming under the care of the agency,

(D) in the case of a hospice program, at the time of initial receipt of hospice care by the individual from the program, and

(E) in the case of an eligible organization (as defined in section 1395mm(b) of this title) or an organization provided payments under section 1395/(a)(1)(A) of this title or a Medicare+Choice organization, at the time of enrollment of the individual with the organization.

(3) In this subsection, the term “advance directive” means a written instruction, such as a living will or durable power of attorney for health care, recognized under State law (whether statutory or as recognized by the courts of the State) and relating to the provision of such care when the individual is incapacitated.

(4) For construction relating to this subsection, see section 14406 of this title (relating to clarification respecting assisted suicide, euthanasia, and mercy killing).

(g) Penalties for Improper Billing

Except as permitted under subsection (a)(2) of this section, any person who knowingly and willfully presents, or causes to be presented, a bill or request for payment inconsistent with an arrangement under subsection (a)(1)(H) of this section or in violation of the requirement for such an arrangement, is subject to a civil money penalty of not to exceed \$2,000. The provisions of section 1320a-7a of this title (other than subsections (a) and (b)) shall apply to a civil money penalty under the previous sentence in the same manner as such provisions apply to a penalty or proceeding under section 1320a-7a(a) of this title.

(h) Dissatisfaction with Determination of Secretary; Appeal by Institutions or Agencies; Single Notice and Hearing

(1)

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

to the Secretary or the Department of Health and Human Services, respectively.

(B) An institution or agency described in subparagraph (A) that has filed for a hearing under subparagraph (A) shall have expedited access to judicial review under this subparagraph in the same manner as providers of services, suppliers, and individuals entitled to benefits under part A of this subchapter or enrolled under part B of this subchapter, or both, may obtain expedited access to judicial review under the process established under section 1395ff(b)(2) of this title. Nothing in this subparagraph shall be construed to affect the application of any remedy imposed under section 1395i-3 of this title during the pendency of an appeal under this subparagraph.

(C)

- (i) The Secretary shall develop and implement a process to expedite proceedings under this subsection in which
 - (I) the remedy of termination of participation has been imposed;
 - (II) a remedy described in clause (i) or (iii) of section 1395i-3(h)(2)(B) of this title has been imposed, but only if such remedy has been imposed on an immediate basis; or
 - (III) a determination has been made as to a finding of substandard quality of care that results in the loss of approval of a

skilled nursing facility's nurse aide training program.

- (ii) Under such process under clause (i), priority shall be provided in cases of termination described in clause (i)(I).
- (iii) Nothing in this subparagraph shall be construed to affect the application of any remedy imposed under section 1395i-3 of this title during the pendency of an appeal under this subparagraph.

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

(i) Intermediate Sanctions for Psychiatric Hospitals

(1) If the Secretary determines that a psychiatric hospital which has an agreement in effect under this section no longer meets the requirements for a psychiatric hospital under this subchapter and further finds that the hospital's deficiencies—

(A) immediately jeopardize the health and safety of its patients, the Secretary shall terminate such agreement; or

(B) do not immediately jeopardize the health and safety of its patients, the Secretary may terminate such agreement, or provide that no payment will be made under this subchapter with respect to any individual admitted to such hospital after the effective date of the finding, or both.

(2) If a psychiatric hospital, found to have deficiencies described in paragraph (1)(B), has not complied with the requirements of this subchapter—

(A) within 3 months after the date the hospital is found to be out of compliance with such requirements, the Secretary shall provide that no payment will be made under this subchapter with respect to any individual admitted to such hospital after the end of such 3-month period, or

(B) within 6 months after the date the hospital is found to be out of compliance with such requirements, no payment may be made under this subchapter with respect to any individual in the hospital until the Secretary finds that the hospital is in compliance with the requirements of this subchapter.

(j) Enrollment Process for Providers of Services and Suppliers

(1) Enrollment process

(A) In general

The Secretary shall establish by regulation a process for the enrollment of providers of services and suppliers under this subchapter. Such process shall include screening of providers and suppliers in accordance with paragraph (2), a provisional period of enhanced oversight in accordance with paragraph (3), disclosure requirements in accordance with paragraph (5), the imposition of temporary enrollment moratoria in accordance with paragraph (7), and the establishment of compliance programs in accordance with paragraph (9).

(B) Deadlines

The Secretary shall establish by regulation procedures under which there are deadlines for actions on applications for enrollment (and, if applicable, renewal of enrollment). The Secretary shall monitor the performance of Medicare administrative contractors in meeting the deadlines established under this subparagraph.

(C) Consultation before changing provider enrollment forms

The Secretary shall consult with providers of services and suppliers before making changes in the provider enrollment forms required of such providers and suppliers to be eligible to submit claims for which payment may be made under this subchapter.

(2) Provider screening

(A) Procedures

Not later than 180 days after March 23, 2010, the Secretary, in consultation with the Inspector General of the Department of Health and Human Services, shall establish procedures under which screening is conducted with respect to providers of medical or other items or services and suppliers under the program under this subchapter, the Medicaid program under subchapter XIX, and the CHIP program under subchapter XXI.

(B) Level of screening

The Secretary shall determine the level of screening conducted under this paragraph accord-

ing to the risk of fraud, waste, and abuse, as determined by the Secretary, with respect to the category of provider of medical or other items or services or supplier. Such screening—

- (i) shall include a licensure check, which may include such checks across States; and
 - (ii) may, as the Secretary determines appropriate based on the risk of fraud, waste, and abuse described in the preceding sentence, include—
 - (I) a criminal background check;
 - (II) fingerprinting;
 - (III) unscheduled and unannounced site visits, including preenrollment site visits;
 - (IV) database checks (including such checks across States); and
 - (V) such other screening as the Secretary determines appropriate.
- (C) Application fees
- (i) Institutional providers

Except as provided in clause (ii), the Secretary shall impose a fee on each institutional provider of medical or other items or services or supplier (such as a hospital or skilled nursing facility) with respect to which screening is conducted under this paragraph in an amount equal to—

- (I) for 2010, \$500; and

(II) for 2011 and each subsequent year, the amount determined under this clause for the preceding year, adjusted by the percentage change in the consumer price index for all urban consumers (all items; United States city average) for the 12-month period ending with June of the previous year.

(ii) Hardship exception; waiver for certain Medicaid providers

The Secretary may, on a case-by-case basis, exempt a provider of medical or other items or services or supplier from the imposition of an application fee under this subparagraph if the Secretary determines that the imposition of the application fee would result in a hardship. The Secretary may waive the application fee under this subparagraph for providers enrolled in a State Medicaid program for whom the State demonstrates that imposition of the fee would impede beneficiary access to care.

(iii) Use of funds

Amounts collected as a result of the imposition of a fee under this subparagraph shall be used by the Secretary for program integrity efforts, including to cover the costs of conducting screening under this paragraph and to carry out this subsection and section 1320a-7k of this title.

(D) Application and enforcement

(i) New providers of services and suppliers

The screening under this paragraph shall apply, in the case of a provider of medical or other items or services or supplier who is not enrolled in the program under this subchapter, subchapter XIX, or subchapter XXI as of March 23, 2010, on or after the date that is 1 year after such date.

(ii) Current providers of services and suppliers

The screening under this paragraph shall apply, in the case of a provider of medical or other items or services or supplier who is enrolled in the program under this subchapter, subchapter XIX, or subchapter XXI as of such date, on or after the date that is 2 years after such date.

(iii) Revalidation of enrollment

Effective beginning on the date that is 180 days after such date, the screening under this paragraph shall apply with respect to the revalidation of enrollment of a provider of medical or other items or services or supplier in the program under this subchapter, subchapter XIX, or subchapter XXI.

(iv) Limitation on enrollment and revalidation of enrollment

In no case may a provider of medical or other items or services or supplier who has not been screened under this paragraph be initially enrolled or reenrolled in the program under this subchapter, subchapter XIX, or

subchapter XXI on or after the date that is 3 years after such date.

(E) Use of information from the Department of Treasury concerning tax debts

In reviewing the application of a provider of services or supplier to enroll or reenroll under the program under this subchapter, the Secretary shall take into account the information supplied by the Secretary of the Treasury pursuant to section 6103(/)(22) of the Internal Revenue Code of 1986, in determining whether to deny such application or to apply enhanced oversight to such provider of services or supplier pursuant to paragraph (3) if the Secretary determines such provider of services or supplier owes such a debt.

(F) Expedited rulemaking

The Secretary may promulgate an interim final rule to carry out this paragraph.

(3) Provisional period of enhanced oversight for new providers of services and suppliers

(A) In general

The Secretary shall establish procedures to provide for a provisional period of not less than 30 days and not more than 1 year during which new providers of medical or other items or services and suppliers, as the Secretary determines appropriate, including categories of providers or suppliers, would be subject to enhanced oversight, such as prepayment review and payment caps, under the program under this subchapter, the Medicaid program under sub-

chapter XIX. and the CHIP program under subchapter XXI.

(B) Implementation

The Secretary may establish by program instruction or otherwise the procedures under this paragraph.

(4) 90-day period of enhanced oversight for initial claims of DME suppliers

For periods beginning after January 1, 2011, if the Secretary determines that there is a significant risk of fraudulent activity among suppliers of durable medical equipment, in the case of a supplier of durable medical equipment who is within a category or geographic area under this subchapter identified pursuant to such determination and who is initially enrolling under such subchapter, the Secretary shall, notwithstanding sections 1395h(c), 1395u(c), and 1395ff(a)(2) of this title, withhold payment under such subchapter with respect to durable medical equipment furnished by such supplier during the 90-day period beginning on the date of the first submission of a claim under such subchapter for durable medical equipment furnished by such supplier.

(5) Increased disclosure requirements

(A) Disclosure

A provider of medical or other items or services or supplier who submits an application for enrollment or revalidation of enrollment in the program under this subchapter, subchapter XIX, or subchapter XXI on or after the date that is 1 year after March 23, 2010, shall disclose (in a form and manner and at such time as deter-

mined by the Secretary) any current or previous affiliation (directly or indirectly) with a provider of medical or other items or services or supplier that has uncollected debt, has been or is subject to a payment suspension under a Federal health care program (as defined in section 1320a-7b(f) of this title), has been excluded from participation under the program under this subchapter, the Medicaid program under subchapter XIX, or the CHIP program under subchapter XXI, or has had its billing privileges denied or revoked.

(B) Authority to deny enrollment

If the Secretary determines that such previous affiliation poses an undue risk of fraud, waste, or abuse, the Secretary may deny such application. Such a denial shall be subject to appeal in accordance with paragraph (7).

(6) Authority to adjust payments of providers of services and suppliers with the same tax identification number for Medicare obligations

(A) In general

Notwithstanding any other provision of this subchapter, in the case of an applicable provider of services or supplier, the Secretary may make any necessary adjustments to payments to the applicable provider of services or supplier under the program under this subchapter in order to satisfy any amount described in subparagraph (B)(ii) due from such obligated provider of services or supplier.

(B) Definitions

In this paragraph:

(i) In general

The term “applicable provider of services or supplier” means a provider of services or supplier that has the same taxpayer identification number assigned under section 6109 of the Internal Revenue Code of 1986 as is assigned to the obligated provider of services or supplier under such section, regardless of whether the applicable provider of services or supplier is assigned a different billing number or national provider identification number under the program under this subchapter than is assigned to the obligated provider of services or supplier.

(ii) Obligated provider of services or supplier

The term “obligated provider of services or supplier” means a provider of services or supplier that owes an amount that is more than the amount required to be paid under the program under this subchapter (as determined by the Secretary).

(7) Temporary moratorium on enrollment of new providers; nonpayment

(A) In general

The Secretary may impose a temporary moratorium on the enrollment of new providers of services and suppliers, including categories of providers of services and suppliers, in the program under this subchapter, under the Medicaid program under subchapter XIX, or under the CHIP program under subchapter XXI

if the Secretary determines such moratorium is necessary to prevent or combat fraud, waste, or abuse under either such program.

(B) Limitation on review

There shall be no judicial review under section 1395ff of this title, section 1395o of this title, or otherwise, of a temporary moratorium imposed under subparagraph (A).

(C) Nonpayment

(i) In general

No payment may be made under this subchapter or under a program described in subparagraph (A) with respect to an item or service described in clause (ii) furnished on or after October 1, 2017.

(ii) Item or service described

An item or service described in this clause is an item or service furnished—

(I) within a geographic area with respect to which a temporary moratorium imposed under subparagraph (A) is in effect; and

(II) by a provider of services or supplier that meets the requirements of clause (iii).

(iii) Requirements

For purposes of clause (ii), the requirements of this clause are that a provider of services or supplier—

- (I) enrolls under this subchapter on or after the effective date of such temporary moratorium; and
 - (II) is within a category of providers of services and suppliers (as described in subparagraph (A)) subject to such temporary moratorium.
- (iv) Prohibition on charges for specified items or services

In no case shall a provider of services or supplier described in clause (ii)(II) charge an individual or other person for an item or service described in clause (ii) furnished on or after October 1, 2017, to an individual entitled to benefits under part A of this subchapter or enrolled under part B of this subchapter or an individual under a program specified in subparagraph (A).

(8) Hearing rights in cases of denial or non-renewal

A provider of services or supplier whose application to enroll (or, if applicable, to renew enrollment) under this subchapter is denied may have a hearing and judicial review of such denial under the procedures that apply under subsection (h)(1)(A) of this section to a provider of services that is dissatisfied with a determination by the Secretary.

(9) Compliance programs

(A) In general

On or after the date of implementation determined by the Secretary under subparagraph (C), a provider of medical or other items or services

or supplier within a particular industry sector or category shall, as a condition of enrollment in the program under this subchapter, subchapter XIX, or subchapter XXI, establish a compliance program that contains the core elements established under subparagraph (B) with respect to that provider or supplier and industry or category.

(B) Establishment of core elements

The Secretary, in consultation with the Inspector General of the Department of Health and Human Services, shall establish core elements for a compliance program under subparagraph (A) for providers or suppliers within a particular industry or category.

(C) Timeline for implementation

The Secretary shall determine the timeline for the establishment of the core elements under subparagraph (B) and the date of the implementation of subparagraph (A) for providers or suppliers within a particular industry or category. The Secretary shall, in determining such date of implementation, consider the extent to which the adoption of compliance programs by a provider of medical or other items or services or supplier is widespread in a particular industry sector or with respect to a particular provider or supplier category.

(k) Quality Reporting by Cancer Hospitals

(1) In general

For purposes of fiscal year 2014 and each subsequent fiscal year, a hospital described in section 1395ww (d)(1)(B)(v) of this title shall submit data to the Secretary in accordance with paragraph (2) with respect to such a fiscal year.

(2) Submission of quality data

For fiscal year 2014 and each subsequent fiscal year, each hospital described in such section shall submit to the Secretary data on quality measures specified under paragraph (3). Such data shall be submitted in a form and manner, and at a time, specified by the Secretary for purposes of this subparagraph.

(3) Quality measures

(A) In general

Subject to subparagraph (B), any measure specified by the Secretary under this paragraph must have been endorsed by the entity with a contract under section 1395aaa(a) of this title.

(B) Exception

In the case of a specified area or medical topic determined appropriate by the Secretary for which a feasible and practical measure has not been endorsed by the entity with a contract under section 1395aaa(a) of this title, the Secretary may specify a measure that is not so endorsed as long as due consideration is given to measures that have been endorsed or adopted by a consensus organization identified by the Secretary.

(C) Time frame

Not later than October 1, 2012, the Secretary shall publish the measures selected under this paragraph that will be applicable with respect to fiscal year 2014.

(4) Public availability of data submitted

The Secretary shall establish procedures for making data submitted under paragraph (4) available to the public. Such procedures shall ensure that a hospital described in section 1395ww(d)(1)(B)(v) of this title has the opportunity to review the data that is to be made public with respect to the hospital prior to such data being made public. The Secretary shall report quality measures of process, structure, outcome, patients' perspective on care, efficiency, and costs of care that relate to services furnished in such hospitals on the Internet website of the Centers for Medicare & Medicaid Services.

42 U.S.C. § 1395ii—

Application of Certain Provisions of Subchapter II

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