SUPREME COURT OF THE UNITED STATES

No. 98–1109

DONNA E. SHALALA, SECRETARY OF HEALTH AND HUMAN SERVICES, ET AL., PETITIONERS *v.* ILLINOIS COUNCIL ON LONG TERM CARE, INC.

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

[February 29, 2000]

JUSTICE BREYER delivered the opinion of the Court.

The question before us is one of jurisdiction. An association of nursing homes sued, *inter alios*, the Secretary of Health and Human Services (HHS) and another federal party (hereinafter Secretary) in Federal District Court claiming that certain Medicare-related regulations violated various statutes and the Constitution. The association invoked the court's federal-question jurisdiction, 28 U. S. C. §1331. The District Court dismissed the suit on the ground that it lacked jurisdiction. It believed that a set of special statutory provisions creates a separate, virtually exclusive, system of administrative and judicial review for denials of Medicare claims; and it held that one of those provisions explicitly barred a §1331 suit. See 42 U. S. C. §1395ii (incorporating to the Medicare Act 42 U. S. C. §405(h), which provides that "[n]o action . . . to recover on any claim" arising under the Medicare laws shall be "brought under section 1331 . . . of title 28"). The Court of Appeals, however, reversed.

We conclude that the statutory provision at issue,

§405(h), as incorporated by §1395ii, bars federal-question jurisdiction here. The association or its members must proceed instead through the special review channel that the Medicare statutes create. See 42 U. S. C. §1395cc(h); §1395cc(b)(2)(A); §1395ii; §§405(b), (g), (h).

I

A

We begin by describing the regulations that the association's lawsuit attacks. Medicare Act Part A provides payment to nursing homes which provide care to Medicare beneficiaries after a stay in hospital. To receive payment, a home must enter into a provider agreement with the Secretary of HHS, and it must comply with numerous statutory and regulatory requirements. State and federal agencies enforce those requirements through inspections. Inspectors report violations, called "deficiencies." And "deficiencies" lead to the imposition of sanctions or "remedies." See generally §§1395i–3, 1395cc.

The regulations at issue focus on the imposition of sanctions or remedies. They were promulgated in 1994, 59 Fed. Reg. 56116, pursuant to a 1987 law that tightened the substantive standards that Medicare (and Medicaid) imposed upon nursing homes and that significantly broadened the Secretary's authority to impose remedies upon violators. Omnibus Budget Reconciliation Act of 1987, §§4201–4218, 101 Stat. 1330–160 to 1330–221 (codified as amended at 42 U. S. C. §1395i–3 (1994 ed. and Supp. III)).

The remedial regulations (and a related manual) in effect tell Medicare-administering agencies how to impose remedies after inspectors find that a nursing home has violated substantive standards. They divide a nursing home's deficiencies into three categories of seriousness depending upon a deficiency's severity, its prevalence at the home, its relation with other deficiencies, and the home's compliance history. Within each category they list

a set of remedies that the agency may, or must, impose. Where, for example, deficiencies "immediately jeopardize the health or safety of . . . residents," the Secretary must terminate the home's provider agreement or appoint new, temporary management. Where deficiencies are less serious, the Secretary may impose lesser remedies, such as civil penalties, transfer of residents, denial of some or all payment, state monitoring, and the like. Where a nursing home, though deficient in some respects, is in "[s]ubstantial compliance," *i.e.*, where its deficiencies do no more than create a "potential for causing minimal harm," the Secretary will impose no sanction or remedy at all. See generally 42 U. S. C. §1395i–3(h); 42 CFR §488.301 (1998); §488.400 *et seq.;* App. 54, 66 (Manual). The statute and regulations also create various review procedures. 42 U. S. C. §§1395cc(b)(2)(A), (h); 42 CFR §431.151 *et seq.* (1998); §488.408(g); 42 CFR pt. 498 (1998).

The association's complaint filed in Federal District Court attacked the regulations as unlawful in four basic ways. In its view: (1) certain terms, *e.g.*, "substantial compliance" and "minimal harm," are unconstitutionally vague; (2) the regulations and manual, particularly as implemented, violate statutory requirements seeking enforcement consistency, 42 U. S. C. §1395i–3(g)(2)(D), and exceed the legislative mandate of the Medicare Act; (3) the regulations create administrative procedures inconsistent with the Federal Constitution's Due Process Clause; and (4) the manual and other agency publications create legislative rules that were not promulgated consistent with the Administrative Procedure Act's demands for "notice and comment" and a statement of "basis and purpose," 5 U. S. C. §553. See App. 18–19, 27–38, 43–49 (Amended Complaint).

B

We next describe the two competing jurisdictional

routes through which the association arguably might seek to mount its legal attack. The route it has followed, federal-question jurisdiction, is set forth in 28 U. S. C. §1331, which simply states that "district courts shall have original jurisdiction of all civil actions arising under the Constitution, laws, or treaties of the United States." The route that it did not follow, the special Medicare review route, is set forth in a complex set of statutory provisions, which must be read together. See Appendix, *infra*. The Medicare Act says that a home

> "dissatisfied . . . with *a determination described in subsection (b)(2)* . . . shall be entitled to a hearing . . . to the same extent as is provided in [the Social Security Act, 42 U. S. C. §]405(b) . . . and 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) (emphasis added).

The cross-referenced subsection (b)(2) gives the Secretary power to terminate an agreement where, for example, the Secretary

> "*has determined* that the provider fails to comply substantially with the provisions [of the Medicare Act] and regulations thereunder . . . ." §1395cc(b)(2)(A) (emphasis added).

The cross-referenced §405(b) describes the nature of the administrative hearing to which the Medicare Act entitles a home that is "dissatisfied" with the Secretary's "determination." The cross-referenced §405(g) provides that a "dissatisfied" home may obtain judicial review in federal district court of "any final decision of the [Secretary] made after a hearing . . . ." Separate statutes provide for administrative and judicial review of civil monetary penalty assessments. §1395i–3(h)(2)(B)(ii); §§1320a–7a(c)(2), (e).

A related Social Security Act provision, 42 U. S. C.

§405(h), channels most, if not all, Medicare claims, through this special review system. It says:

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

Title 42 U. S. C. §1395ii makes §405(h) applicable to the Medicare Act "to the same extent as" it applies to the Social Security Act.

C

The case before us began when the Illinois Council on Long Term Care, Inc. (Council), an association of about 200 Illinois nursing homes participating in the Medicare (or Medicaid) program, filed the complaint we have described, *supra*, at 3, in Federal District Court. (Medicaid is not at issue in this Court.) The District Court, as we have said, dismissed the complaint for lack of federal-question jurisdiction. No. 96 C 2953 (ND Ill., Mar. 31, 1997), App. to Pet. for Cert. 13a, 15a. In doing so, the court relied upon §405(h) as interpreted by this Court in *Weinberger* v. *Salfi*, 422 U. S. 749 (1975), and *Heckler* v. *Ringer*, 466 U. S. 602 (1984). App to Pet. for Cert. 15a–19a.

The Court of Appeals reversed the dismissal. 143 F. 3d 1072 (CA7 1998). In its view, a later case, *Bowen* v. *Michigan Academy of Family Physicians*, 476 U. S. 667 (1986), had significantly modified this Court's earlier case law. Other Circuits have understood *Michigan Academy* differ-

ently. See *Michigan Assn. of Homes and Servs. for the Aging* v. *Shalala*, 127 F. 3d 496, 500–501 (CA6 1997); *American Academy of Dermatology* v. *HHS*, 118 F. 3d 1495, 1499–1501 (CA11 1997); *St. Francis Medical Center* v. *Shalala*, 32 F. 3d 805, 812–813 (CA3 1994), cert. denied, 514 U. S. 1016 (1995); *Farkas* v. *Blue Cross & Blue Shield*, 24 F. 3d 853, 855–860 (CA6 1994); *Abbey* v. *Sullivan*, 978 F. 2d 37, 41–44 (CA2 1992); *National Kidney Patients Assn.* v. *Sullivan*, 958 F. 2d 1127, 1130–1134 (CADC 1992), cert. denied, 506 U. S. 1049 (1993). We granted certiorari to resolve those differences.

II

Section 405(h) purports to make exclusive the judicial review method set forth in §405(g). Its second sentence says that "[n]o findings of fact or decision of the [Secretary] shall be reviewed by any person, tribunal, or governmental agency except as herein provided." §405(h). Its third sentence, directly at issue here, says that "[n]o action against the United States, the [Secretary], or any officer or employee thereof shall be brought under section 1331 or 1346 of title 28 *to recover on any claim arising under this subchapter.*" (Emphasis added.)

The scope of the italicized language "to recover on any claim arising under" the Social Security (or, as incorporated through §1395ii, the Medicare) Act is, if read alone, uncertain. Those words clearly apply in a typical Social Security or Medicare benefits case, where an individual seeks a monetary benefit from the agency (say a disability payment, or payment for some medical procedure), the agency denies the benefit and the individual challenges the lawfulness of that denial. The statute plainly bars §1331 review in such a case, irrespective of whether the individual challenges the agency's denial on evidentiary, rule-related, statutory, constitutional, or other legal grounds. But does the statute's bar apply when one who

might later seek money or some other benefit from (or contest the imposition of a penalty by) the agency challenges in advance (in a §1331 action) the lawfulness of a policy, regulation, or statute that *might* later bar recovery of that benefit (or authorize the imposition of the penalty)? Suppose, as here, a group of such individuals, needing advance knowledge for planning purposes, together bring a §1331 action challenging such a rule or regulation on general legal grounds. Is such an action one "to recover on any claim arising under" the Social Security or Medicare Acts? That, in effect, is the question before us.

III

In answering the question, we temporarily put the case on which the Court of Appeals relied, *Michigan Academy, supra,* to the side. Were we not to take account of that case, §405(h) as interpreted by the Court's earlier cases of *Weinberger* v. *Salfi, supra,* and *Heckler* v. *Ringer, supra,* would clearly bar this §1331 lawsuit.

In *Salfi,* a mother and a daughter, filing on behalf of themselves and a class of individuals, brought a §1331 action challenging the constitutionality of a statutory provision that, if valid, would deny them Social Security benefits. See 42 U. S. C. §§416(c)(5), (e)(2) (imposing a duration-of-relationship Social Security eligibility requirement for surviving wives and stepchildren of deceased wage earners). The mother and daughter had appeared before the agency but had not completed its processes. The class presumably included some who had, and some who had not, appeared before the agency; the complaint did not say. This Court held that §405(h) barred §1331 jurisdiction for all members of the class because "it is the Social Security Act which provides both the standing and the substantive basis for the presentation of th[e] constitutional contentions." *Salfi, supra,* at 760–761. The Court added that the bar applies "irrespec-

tive of whether resort to judicial processes is necessitated by discretionary decisions of the Secretary or by his nondiscretionary application of allegedly unconstitutional statutory restrictions." 422 U. S., at 762. It also pointed out that the bar did not "preclude constitutional challenges," but simply "require[d] that they be brought" under the same "jurisdictional grants" and "in conformity with the same standards" applicable "to nonconstitutional claims arising under the Act." *Ibid.*

We concede that the Court also pointed to certain special features of the case not present here. The plaintiff class had asked for relief that included a direction to the Secretary to pay Social Security benefits to those entitled to them but for the challenged provision. See *id.*, at 761. And the Court thought this fact helped make clear that the action arose "under the Act whose benefits [were] sought." *Ibid.* But in a later case, *Ringer*, the Court reached a similar result despite the absence of any request for such relief. See 466 U. S., at 616, 623.

In *Ringer*, four individuals brought a §1331 action challenging the lawfulness (under statutes and the Constitution) of the agency's determination not to provide Medicare Part A reimbursement to those who had undergone a particular medical operation. The Court held that §405(h) barred §1331 jurisdiction over the action, even though the challenge was in part to the agency's procedures, the relief requested amounted simply to a declaration of invalidity (not an order requiring payment), and one plaintiff had as yet no valid claim for reimbursement because he had not even undergone the operation and would likely never do so unless a court set aside as unlawful the challenged agency "no reimbursement" determination. See *id.*, at 614–616, 621–623. The Court reiterated that §405(h) applies where "both the standing and the substantive basis for the presentation" of a claim is the Medicare Act, *id.*, at 615 (quoting *Salfi*, 422 U. S., at 760–761) (internal quotation marks

omitted), adding that a "claim for future benefits" is a §405(h) "claim," 466 U. S., at 621–622, and that "all aspects" of any such present or future claim must be "channeled" through the administrative process, *id.*, at 614. See also *Your Home Visiting Nurse Services, Inc.* v. *Shalala*, 525 U. S. 449, 456 (1999); *Califano* v. *Sanders*, 430 U. S. 99, 103–104, n. 3 (1977).

As so interpreted, the bar of §405(h) reaches beyond ordinary administrative law principles of "ripeness" and "exhaustion of administrative remedies," see *Salfi*, *supra*, at 757– doctrines that in any event normally require channeling a legal challenge through the agency. See *Abbott Laboratories* v. *Gardner*, 387 U. S. 136, 148–149 (1967) (ripeness); *McKart* v. *United States*, 395 U. S. 185, 193–196 (1969) (exhaustion). Indeed, in this very case, the Seventh Circuit held that several of respondent's claims were not ripe and remanded for ripeness review of the remainder. 143 F. 3d, at 1077–1078. Doctrines of "ripeness" and "exhaustion" contain exceptions, however, which exceptions permit early review when, for example, the legal question is "fit" for resolution and delay means hardship, see *Abbott Laboratories*, *supra*, at 148–149, or when exhaustion would prove "futile," see *McCarthy* v. *Madigan*, 503 U. S. 140, 147–148 (1992); *McKart*, *supra*, at 197–201. (And sometimes Congress expressly authorizes pre-enforcement review, though not here. See, *e.g.*, 15 U. S. C. §2618(a)(1)(A) (Toxic Substances Control Act).)

Insofar as §405(h) prevents application of the "ripeness" and "exhaustion" exceptions, *i.e.*, insofar as it demands the "channeling" of virtually all legal attacks through the agency, it assures the agency greater opportunity to apply, interpret, or revise policies, regulations, or statutes without possibly premature interference by different individual courts applying "ripeness" and "exhaustion" exceptions case by case. But this assurance comes at a price, namely, occasional individual, delay-related hardship. In the

context of a massive, complex health and safety program such as Medicare, embodied in hundreds of pages of statutes and thousands of pages of often interrelated regulations, any of which may become the subject of a legal challenge in any of several different courts, paying this price may seem justified. In any event, such was the judgment of Congress as understood in *Salfi* and *Ringer*. See *Ringer*, 466 U. S., at 627; *Salfi*, *supra*, at 762.

Despite the urging of the Council and supporting *amici*, we cannot distinguish *Salfi* and *Ringer* from the case before us. Those cases themselves foreclose distinctions based upon the "potential future" versus the "actual present" nature of the claim, the "general legal" versus the "fact-specific" nature of the challenge, the "collateral" versus "non-collateral" nature of the issues, or the "declaratory" versus "injunctive" nature of the relief sought. Nor can we accept a distinction that limits the scope of §405(h) to claims for monetary benefits. Claims for money, claims for other benefits, claims of program eligibility, and claims that contest a sanction or remedy may all similarly rest upon individual fact-related circumstances, may all similarly dispute agency policy determinations, or may all similarly involve the application, interpretation, or constitutionality of interrelated regulations or statutory provisions. There is no reason to distinguish among them in terms of the language or in terms of the purposes of §405(h). Section 1395ii's blanket incorporation of that provision into the Medicare Act as a whole certainly contains no such distinction. Nor for similar reasons can we here limit those provisions to claims that involve "amounts."

The Council cites two other cases in support of its efforts to distinguish *Salfi* and *Ringer*: *McNary* v. *Haitian Refugee Center, Inc.*, 498 U. S. 479 (1991), and *Mathews* v. *Eldridge*, 424 U. S. 319 (1976). In *Haitian Refugee Center*, the Court held permissible a §1331 challenge to "a group of decisions

or a practice or procedure employed in making decisions" despite an immigration statute that barred §1331 challenges to any Immigration and Naturalization Service "'determination respecting an application for adjustment of status'" under the Special Agricultural Workers' program. 498 U. S., at 491–498. *Haitian Refugee Center*'s outcome, however, turned on the different language of that different statute. Indeed, the Court suggested that statutory language similar to the language at issue here– any claim "arising under" the Medicare or Social Security Acts, §405(h)– would have led it to a different legal conclusion. See *id.*, at 494 (using as an example a statute precluding review of "'all causes . . . arising under any of'" the immigration statutes).

In *Eldridge*, the Court held permissible a District Court lawsuit challenging the constitutionality of agency procedures authorizing termination of Social Security disability payments without a pretermination hearing. See 424 U. S., at 326–332. *Eldridge*, however, is a case in which the Court found that the respondent *had followed* the special review procedures set forth in §405(g), thereby *complying with*, rather than *disregarding*, the strictures of §405(h). See *id.*, at 326–327 (holding jurisdiction available only under §405(g)). The Court characterized the constitutional issue the respondent raised as "collateral" to his claim for benefits, but it did so as a basis for requiring the agency to excuse, where the agency would not do so on its own, see *Salfi*, 422 U. S., at 766–767, some (but not all) of the procedural steps set forth in §405(g). 424 U. S., at 329–332 (identifying collateral nature of the claim and irreparable injury as reasons to excuse §405(g)'s exhaustion requirements); see also *Bowen* v. *City of New York*, 476 U. S. 467, 483–485 (1986) (noting that *Eldridge* factors are not to be mechanically applied). The Court nonetheless held that §405(g) contains the nonwaivable and nonexcusable requirement that an individual present a claim to the

agency before raising it in court. See *Ringer, supra,* at 622; *Eldridge, supra,* at 329; *Salfi, supra,* at 763–764. The Council has not done so here, and thus cannot establish jurisdiction under §405(g).

The upshot is that without *Michigan Academy* the Council cannot win. Its precedent-based argument must rest primarily upon that case.

IV

The Court of Appeals held that *Michigan Academy* modified the Court's earlier holdings by limiting the scope of "1395ii and therefore §405(h)" to "amount determinations." 143 F. 3d, at 1075–1076. But we do not agree. *Michigan Academy* involved a §1331 suit challenging the lawfulness of HHS regulations that governed procedures used to calculate benefits under Medicare Part B– which Part provides voluntary supplementary medical insurance, *e.g.,* for doctors' fees. See *Michigan Academy*, 476 U. S., at 674–675; *United States* v. *Erika, Inc.,* 456 U. S. 201, 202–203 (1982). The Medicare statute, as it then existed, provided for only limited review of Part B decisions. It allowed the equivalent of §405(g) review for "eligibility" determinations. See 42 U. S. C. §1395ff(b)(1)(B) (1982 ed.). It required private insurance carriers (administering the Part B program) to provide a "fair hearing" for disputes about Part B "amount determinations." §1395u(b)(3)(C). But that was all.

Michigan Academy first discussed the statute's total silence about review of "challenges mounted against the *method* by which . . . amounts are to be determined." 476 U. S., at 675. It held that this silence meant that, although review was not available *under §405(g),* the silence did not itself foreclose other forms of review, say review in a court action brought under §1331. See *id.,* at 674–678. Cf. *Erika, supra,* at 208 (holding that the Medicare Part B statute's *explicit* reference to carrier hearings for amount

disputes does foreclose *all* further agency or court review of "amount determinations").

The Court then asked whether §405(h) barred 28 U. S. C. §1331 review of challenges to methodology. Noting the Secretary's *Salfi/Ringer*-based argument that §405(h) barred §1331 review of *all* challenges arising under the Medicare Act and the respondents' counter-argument that §405(h) barred challenges to "methods" only where §405(g) review was available, see *Michigan Academy*, 476 U. S., at 679, the Court wrote:

> "Whichever may be the better reading of *Salfi* and *Ringer*, we need not pass on the meaning of §405(h) in the abstract to resolve this case. Section 405(h) does not apply on its own terms to Part B of the Medicare program, but is instead incorporated *mutatis mutandis* by §1395ii. The legislative history of both the statute establishing the Medicare program and the 1972 amendments thereto provides specific evidence of Congress' intent to foreclose review only of 'amount determinations'— *i.e.*, those [matters] . . . remitted finally and exclusively to adjudication by private insurance carriers in a 'fair hearing.' By the same token, matters which Congress did *not* delegate to private carriers, such as challenges to the validity of the Secretary's instructions and regulations, are cognizable in courts of law." *Id.*, at 680 (footnote omitted).

The Court's words do not limit the scope of §405(h) itself to instances where a plaintiff, invoking §1331, seeks review of an "amount determination." Rather, the Court said that it would "*not* pass on the meaning of §405(h) in the abstract." *Ibid.* (emphasis added). Instead it focused upon the Medicare Act's cross-referencing provision, §1395ii, which makes §405(h) applicable "*to the same extent as*" it is "applicable" to the Social Security Act. (Emphasis added). It interpreted that phrase as applying

§405(h) *"mutatis mutandis," i.e.*, "[a]ll necessary changes having been made." Black's Law Dictionary 1039 (7th ed. 1999). And it applied §1395ii with one important change of detail– a change produced by *not* applying §405(h) where its application to a particular category of cases, such as Medicare Part B "methodology" challenges, would not lead to a channeling of review through the agency, but would mean no review at all. The Court added that a " 'serious constitutional question' . . . would arise if we construed §1395ii to deny a judicial forum for constitutional claims arising under Part B." 476 U. S., at 681, n. 12 (quoting *Salfi*, 422 U. S., at 762 (citing *Johnson* v. *Robison*, 415 U. S. 361, 366–367 (1974))).

More than that: Were the Court of Appeals correct in believing that *Michigan Academy* limited the scope of §405(h) itself to "amount determinations," that case would have significantly affected not only Medicare Part B cases but cases arising under the Social Security Act and Medicare Part A as well. It accordingly would have overturned or dramatically limited this Court's earlier precedents, such as *Salfi* and *Ringer*, which involved, respectively, those programs. It would, moreover, have created a hardly justifiable distinction between "amount determinations" and many other similar HHS determinations, see *supra*, at 10. And we do not understand why Congress, as JUSTICE STEVENS believes, *post*, at 1–2 (dissenting opinion), would have wanted to compel Medicare patients, but not Medicare providers, to channel their claims through the agency. Cf. Brief for Respondent 7–8, 18–21, 30–31 (apparently conceding the point). This Court does not normally overturn, or so dramatically limit, earlier authority *sub silentio*. And we agree with those Circuits that have held the Court did not do so in this instance. See *Michigan Assn. of Homes and Servs.*, 127 F. 3d, at 500–501; *American Academy of Dermatology*, 118 F. 3d, at 1499–1501; *St. Francis Medical Center*, 32 F. 3d, at 812; *Farkas*,

24 F. 3d, at 855–861; *Abbey*, 978 F. 2d, at 41–44; *National Kidney Patients Assn.*, 958 F. 2d, at 1130–1134.

JUSTICE THOMAS maintains that *Michigan Academy* "must have established," by way of a new interpretation of §1395ii, the critical distinction between a dispute about an agency determination in a particular case and a more general dispute about, for example, the agency's authority to promulgate a set of regulations, *i.e*, the very distinction that this Court's earlier cases deny. *Post*, at 7 (dissenting opinion). He says that, in this respect we have mistaken *Michigan Academy*'s "reasoning" (the presumption against preclusion of judicial review) for its "holding." *Post*, at 8–9. And, he finds the holding consistent with earlier cases such as *Ringer* because, he says, in *Ringer* everyone simply assumed without argument that §1395ii's channeling provision fully incorporated the whole of §405(h). *Post*, at 9–10.

For one thing, the language to which JUSTICE THOMAS points simply says that "Congres[s] inten[ded] to foreclose review only of 'amount determinations'" and not "matters which Congress did *not delegate to private carriers, such as* challenges to the validity of the Secretary's instructions and regulations," *Michigan Academy, supra*, at 680 (emphasis added). That language refers to particular features of the Medicare Part B program– "private carriers" and "amount determinations"– which are not here before us. And its reference to "foreclosure" of review quite obviously cannot be taken to refer to §1395ii because, as we have explained, §1395ii is a channeling requirement, not a foreclosure provision– of "amount determinations" or anything else. In short, it is difficult to reconcile JUSTICE THOMAS' characterization of *Michigan Academy* as a holding that *§1395ii* is "trigger[ed]" only by "challenges to . . . particular determinations," *post*, at 9, with the *Michigan Academy* language to which he points.

Regardless, it is more plausible to read *Michigan*

Academy as *holding* that §1395ii does not apply §405(h) where application of §405(h) would not simply channel review through the agency, but would mean no review at all. And contrary to JUSTICE SCALIA's suggestion, *post*, at 1 (dissenting opinion), that single rule applies to Medicare Part A as much as to Medicare Part B. This latter holding, as we have said, has the virtues of consistency with *Michigan Academy*'s actual language; consistency with the holdings of earlier cases such as *Ringer;* and consistency with the distinction that this Court has often drawn between a total preclusion of review and postponement of review. See, *e.g.*, *Salfi*, *supra*, at 762 (distinguishing §405(h)'s channeling requirement from the complete preclusion of judicial review at issue in *Robison*, *supra*, at 373); *Thunder Basin Coal Co.* v. *Reich*, 510 U. S. 200, 207, n. 8 (1994) (strong presumption against preclusion of review is not implicated by provision postponing review); *Haitian Refugee Center*, 498 U. S., at 496–499 (distinguishing between *Ringer* and *Michigan Academy* and finding the case governed by the latter because the statute precluded all meaningful judicial review). JUSTICE THOMAS refers to an "antichanneling" presumption (a "presumption in favor of preenforcement review," *post*, at 15–16). But any such presumption must be far weaker than a presumption against preclusion of all review in light of the traditional ripeness doctrine, which often requires initial presentation of a claim to an agency. As we have said, *supra*, at 9–10, Congress may well have concluded that a universal obligation to present a legal claim first to HHS, though postponing review in some cases, would produce speedier, as well as better, review overall. And this Court crossed the relevant bridge long ago when it held that Congress, in both the Social Security Act and the Medicare Act, insisted upon an initial presentation of the matter to the agency. *Ringer*, 466 U. S., at 627; *Salfi*, *supra*, at 762. *Michigan Academy* does not require that we reconsider that long-

standing interpretation.

V

The Council argues that in any event it falls within the exception that *Michigan Academy* creates, for here as there, it can obtain no review at all unless it can obtain judicial review in a §1331 action. In other words, the Council contends that application of §1395ii's channeling provision to the portion of the Medicare statute and the Medicare regulations at issue in this case will amount to the "practical equivalent of a total denial of judicial review." *Haitian Refugee Center*, *supra*, at 497. The Council, however, has not convinced us that is so.

The Council says that the special review channel that the Medicare statutes create applies only where the Secretary *terminates* a home's provider agreement; it is not available in the more usual case involving imposition of a lesser remedy, say the transfer of patients, the withholding of payments, or the imposition of a civil monetary penalty.

We have set forth the relevant provisions above, *supra* at 4–5; Appendix, *infra*. The specific judicial review provision, §405(g), authorizes judicial review of "any final decision of the [Secretary] made after a [§405(b)] hearing." A further relevant provision, §1395cc(h)(1), authorizes a §405(b) hearing whenever a home is "dissatisfied . . . with a *determination described* in subsection (b)(2)." (Emphasis added.) And subsection (b)(2) authorizes the Secretary to terminate an agreement, whenever she *"has determined* that the provider fails to comply substantially with" statutes, agreements, or "regulations." §1395cc(b)(2)(A) (emphasis added).

The Secretary states in her brief that the relevant "determination" that entitles a "dissatisfied" home to review is any determination that a provider has failed to comply substantially with the statute, agreements, or regulations,

whether termination or *"some other remedy* is imposed." Reply Brief for Petitioners 14 (emphasis added). The Secretary's regulations make clear that she so interprets the statute. See 42 CFR §§498.3(b)(12), 498.1(a)–(b)(1998). The statute's language, though not free of ambiguity, bears that interpretation. And we are aware of no convincing countervailing argument. We conclude that the Secretary's interpretation is legally permissible. See *Chevron U. S. A. Inc.* v. *Natural Resources Defense Council, Inc.*, 467 U. S. 837, 843 (1984); *Your Home Visiting Nurse Services*, 525 U. S., at 453; see also 42 U. S. C. §1395i3h(2)(B)(ii) (providing a different channel for administrative and judicial review of decisions imposing civil monetary penalties.)

The Council next argues that the regulations, as implemented by the enforcement agencies, deny review in practice by (1) insisting that a nursing home with deficiencies present a corrective plan, (2) imposing no further sanction or remedy if it does so, but (3) threatening termination if it does not. See 42 CFR §§488.402(d), 488.456(b)(ii) (1998). Because a home cannot risk termination, the Council adds, it must always submit a plan, thereby avoiding imposition of a remedy, but simultaneously losing its opportunity to contest the lawfulness of any remedy-related rules or regulations. See §498.3(b)(12). And, the Council's *amici* assert, compliance actually harms the home by subjecting it to increased sanctions later on by virtue of the unreviewed deficiency findings, and because the agency makes deficiency findings public on the Internet, §488.325.

The short, conclusive answer to these contentions is that the Secretary denies any such practice. She states in her brief that a nursing home with deficiencies can test the lawfulness of her regulations simply by refusing to submit a plan and incurring a minor penalty. Minor penalties, she says, are the norm, for "terminations from the pro-

gram are rare and generally reserved for the most egregious recidivist institutions." Reply Brief for Petitioners 18; *ibid.* (HHS reports that only 25 out of more than 13,000 nursing homes were terminated in 1995–1996). She adds that the "remedy imposed on a facility that fails to submit a plan of correction or to correct a deficiency– and appeals the deficiency– is no different than the remedy the Secretary ordinarily would impose in the first instance." *Ibid.* Nor do the regulations "cause providers to suffer more severe penalties in later enforcement actions based on findings that are unreviewable." *Ibid.* The Secretary concedes that a home's deficiencies are posted on the Internet, but she notes that a home can post a reply. See *id.*, at 20, n. 20.

The Council gives us no convincing reason to doubt the Secretary's description of the agency's general practice. We therefore need not decide whether a general agency practice that forced nursing homes to abandon legitimate challenges to agency regulations could amount to the "practical equivalent of a total denial of judicial review," *Haitian Refugee Center*, 498 U. S., at 497. Contrary to what JUSTICE THOMAS says, *post*, at 11–12, 20–21, we do not hold that an individual party could circumvent §1395ii's channeling requirement simply because that party shows that postponement would mean added inconvenience or cost in an isolated, particular case. Rather, the question is whether, as applied generally to those covered by a particular statutory provision, hardship likely found in many cases turns what appears to be simply a channeling requirement into *complete* preclusion of judicial review. See *Haitian Refugee Center*, *supra*, at 496–497. Of course, individual hardship may be mitigated in a different way, namely, through excusing a number of the steps in the agency process, though not the step of presentment of the matter to the agency. See *supra*, at 11–12; *infra*, at 20–21. But again, the Council has not shown anything other than potentially

isolated instances of the inconveniences sometimes associated with the postponement of judicial review.

The Council complains that a host of procedural regulations unlawfully limit the extent to which the agency itself will provide the administrative review channel leading to judicial review, for example, regulations insulating from review decisions about a home's level of noncompliance or a determination to impose one, rather than another, penalty. See 42 CFR §§431.153(b), 488.408(g)(2), 498.3(d)(10)(ii)(1998). The Council's members remain free, however, after following the special review route that the statutes prescribe, to contest in court the lawfulness of any regulation or statute upon which an agency determination depends. The fact that the agency might not provide a hearing for that *particular contention*, or may lack the power to provide one, see *Sanders*, 430 U. S., at 109 ("Constitutional questions obviously are unsuited to resolution in administrative hearing procedures . . ."); *Salfi*, 422 U. S., at 764; Brief for Petitioners 45, is beside the point because it is the "action" arising under the Medicare Act that must be channeled through the agency. See *Salfi*, *supra*, at 762. After the action has been so channeled, the court will consider the contention when it later reviews the action. And a court reviewing an agency determination under §405(g) has adequate authority to resolve any statutory or constitutional contention that the agency does not, or cannot, decide, see *Thunder Basin Coal*, 510 U. S., at 215, and n. 20; *Haitian Refugee Center*, *supra*, at 494; *Ringer*, 466 U. S., at 617; *Salfi*, *supra*, at 762, including, where necessary, the authority to develop an evidentiary record.

Proceeding through the agency in this way provides the agency the opportunity to reconsider its policies, interpretations, and regulations in light of those challenges. Nor need it waste time, for the agency can waive many of the procedural steps set forth in §405(g), see *Salfi*, *supra*, at

767, and a court can deem them waived in certain circumstances, see *Eldridge*, 424 U. S., at 330–331, even though the agency technically holds no "hearing" on the claim. See *Salfi*, *supra*, at 763–767 (holding that Secretary's decision not to challenge the sufficiency of the appellees' exhaustion was in effect a determination that the agency had rendered a "final decision" within the meaning of §405(g)); *Eldridge*, *supra*, at 331–332, and n. 11 (invoking practical conception of finality to conclude that collateral nature of claim and potential irreparable injury from delayed review satisfy the "final decision" requirement of §405(g)). At a minimum, however, the matter must be presented to the agency prior to review in a federal court. This the Council has not done.

Finally, the Council argues that, because it is an association, not an individual, it cannot take advantage of the special review channel, for the statute authorizes review through that channel only at the request of a "dissatisfied" "institution or agency." §1395cc(h)(1). The Council speaks only on behalf of its member institutions, and thus has standing only because of the injury those members allegedly suffer. See *Arizonans for Official English* v. *Arizona*, 520 U. S. 43, 65–66 (1997); *Hunt* v. *Washington State Apple Advertising Comm'n*, 432 U. S. 333, 343 (1977). It is essentially their rights to review that are at stake. And the statutes that create the special review channel adequately protect those rights.

VI

For these reasons, this case cannot fit within *Michigan Academy*'s exception. The bar of §405(h) applies. The judgment of the Court of Appeals is

Reversed.

APPENDIX TO THE OPINION OF THE COURT

42 U. S. C. §1395cc(h)(1) provides:

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

42 U. S. C. §1395cc(b) provides, in relevant part:

> "(b) Termination or nonrenewal of agreements
>
> . . . . .
>
> "(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."

42 U. S. C. §405(b) provides, in relevant part

"(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.

. . . . .

"(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."

42 U. S. C. §405(g) provides:

"(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 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."

42 U. S. C. §405(h) provides:

"(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."

42 U. S. C. §1395ii provides:

"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."

28 U. S. C. §1331 provides:

"Federal question. The district courts shall have original jurisdiction of all civil actions arising under the Constitution, laws, or treaties of the United States."